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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 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 or suspension 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 85

### **Educational Examiners Board[282]**

Replace Chapter 13

Replace Chapter 22

Replace Chapter 24

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

Replace Chapters 2 and 3

Replace Chapters 5 to 7

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

Replace Analysis

Replace Chapter 9

Replace Chapters 77 and 78

Replace Chapter 83

Replace Chapters 95 to 100

Replace Chapter 187

### **Inspections and Appeals Department[481]**

Replace Chapters 50 and 51

Replace Chapter 58

Replace Chapter 67

### **Racing and Gaming Commission[491]**

Replace Analysis

Replace Chapters 1 and 2

Replace Chapter 5

Replace Chapter 8

Replace Chapters 10 to 14

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

Replace Analysis

Replace Chapter 4

Replace Chapter 121

Replace Chapter 131

Replace Chapter 150

Replace Chapter 511  
Replace Chapter 620

**Labor Services Division[875]**  
Replace Chapter 32

CHAPTER 85  
WEIGHTS AND MEASURES

[Appeared as Ch 14, 1973 IDR]  
[Certain rules renumbered 5/3/78]

All tolerances and specifications for the weights and measures division were adopted from the  
U.S. Bureau of Standards Handbook II, 44 published September 1949.  
[Prior to 7/27/88 see Agriculture Department 30—Ch 55]

WEIGHTS

**21—85.1(215) “Sensibility reciprocal” defined.** The term “*sensibility reciprocal*” is defined as to the weight required to move the position of equilibrium of the beam, pan, pointer or other indicating device of a scale, a definite amount.

This rule is intended to implement Iowa Code section 215.18.

**21—85.2(215) “Platform scale” defined.** Rescinded IAB 3/31/04, effective 5/5/04.

**21—85.3(215) For vehicle, axle-load, livestock, animal, crane and railway track scales.** Rescinded IAB 3/31/04, effective 5/5/04.

**21—85.4** Reserved.

**21—85.5(215) “Counter scale” defined.** A “*counter scale*” is a scale of any type which is especially adopted on account of its compactness, light weight, moderate capacity and arrangements of parts for use upon a counter, bench, or table.

**21—85.6(215) “Spring and computing scales” defined.** A “*spring scale*” is a scale in which the weight indications depend upon the change of shape or dimensions of an elastic body or system of such bodies.

**85.6(1)** A “*computing scale*” is a scale which, in addition to indicating the weight, indicates the total price of the amount of commodity weighed for a series of unit prices and must be correct in both its weight and value indications.

**85.6(2)** All computing scales shall be equipped with weight indicators and charts on both the dealer’s and customer’s sides.

**85.6(3)** Tolerances for both the spring scale and the computing scale shall not be greater than that for counter scales.

This rule is intended to implement Iowa Code section 215.18.

**21—85.7(215) “Automatic grain scale” defined.** The “*automatic grain scale*” is one so constructed with a mechanical device that a stream of grain flowing into its hopper can be checked at any given weight, long enough to register said weight and dump the load. The garner above the scale should have at least three times the capacity of the scale to ensure a steady flow at all times.

On automatic-indicating scales. On a particular scale, the maintenance tolerances applied shall be not smaller than one-fourth the value of the minimum reading-face graduation; the acceptance tolerances applied shall be not smaller than one-eighth the value of the minimum reading-face graduation.

However, on a prepacking scale (see D.11, D.12) having graduated intervals of less than one-half ounce, the maintenance tolerances applied shall not be smaller than one-eighth ounce and the acceptance tolerances applied shall be not smaller than one-sixteenth ounce.

This rule is intended to implement Iowa Code section 215.18.

**21—85.8(215) “Motor truck scales” defined.** “*Motor truck scales*” are scales built by the manufacturer for the use of weighing commodities transported by motor truck.

This rule is intended to implement Iowa Code section 215.18.

**21—85.9(215) “Livestock scales” defined.** “*Livestock scales*” are scales which are constructed with stock racks, or scales which are being used to weigh livestock.

This rule is intended to implement Iowa Code section 215.18.

**21—85.10(215) “Grain dump scales” defined.** “*Grain dump scales*” are scales so constructed that the truck may be unloaded without being moved from the scale platform.

The above-mentioned scales must be approved by the department. This approval being based upon blueprints and specifications submitted for this purpose.

This rule is intended to implement Iowa Code section 215.18.

**21—85.11(215) Scale pit.**

**85.11(1)** In the construction of a scale pit, walls must be of reinforced concrete. A slab floor must be installed in the pit. The floor must be at least 12 inches thick with a minimum of grade 40 reinforcement rod running into all piers and sidewalls, installed according to the manufacturer’s specifications. There shall be an approach at each end of the scale of not less than ten feet, and said approach shall be of reinforced concrete 12 inches thick on a level with the scale deck.

**85.11(2)** Electronic scales shall have a vertical clearance of not less than four feet from the floor line to the bottom of the I-beam of the scale bridge, thus providing adequate access for inspection and maintenance. The load-bearing supports of all scales installed in a fixed location shall be constructed to ensure the strength, rigidity and permanence required for proper scale performance.

This rule is intended to implement Iowa Code section 215.15.

**21—85.12(215) Pitless scales.** A person may install pitless electronic, self-contained and vehicle scales in a permanent location provided the following conditions for the construction are incorporated:

**85.12(1)** Scale installation applications and permits must be submitted to the department of agriculture and land stewardship the same as the pit scale installation, with specifications being furnished by the manufacturer, for approval.

**85.12(2)** Piers shall extend below the frost line or be set on solid bed rock; and they shall be of reinforced concrete.

**85.12(3)** A reinforced concrete slab the width of the scale, at least six inches thick, shall run full length under the scale. Slab and piers shall be tied together with reinforcement rod, with a minimum clearance of eight inches between floor and weighbridge.

**85.12(4)** Reinforced portland cement approaches at least 12 inches thick, ten feet long and as wide as the scale, shall be provided on each end in a level plane with the scale platform.

**85.12(5)** Scale shall be installed at an elevation to ensure adequate drainage away from scale.

**85.12(6)** Scale platform and indicator shall be protected from wind and other elements which could cause inaccurate operation of the scale.

This rule is intended to implement Iowa Code section 215.18.

**21—85.13(215) Master weights.** Master scale test weights used for checking scales after being overhauled must be sealed by the department of agriculture and land stewardship, division of weights and measures, as to their accuracy once each year. Said weights after being sealed are to be used only as master test weights.

This rule is intended to implement Iowa Code section 215.17.

**21—85.14(215) Scale design.** A scale shall be of such materials and construction that (1) it will support a load of its full nominal capacity without developing undue stresses or deflections, (2) it may reasonably be expected to withstand normal usage without undue impairment of accuracy or the correct functioning of parts, and (3) it will be reasonably permanent in adjustment.

**85.14(1) Stability of indications.** A scale shall be capable of repeating with reasonable precision its indications and recorded representations. This requirement shall be met irrespective of repeated manipulation of any scale element in a manner duplicating normal usage, including (a) displacement of

the indicating elements to the full extent allowed by the construction of the scale, (b) repeated operation of a locking device, and (c) repeated application or removal of unit weights.

**85.14(2) *Interchange or reversal of parts.*** Parts which may readily be interchanged or reversed in the course of normal usage shall be so constructed that their interchange or reversal will not materially affect the zero-load balance or the performance of the scale. Parts which may be interchanged or reversed in normal field assembly shall be (a) so constructed that their interchange or reversal will not affect the performance of the scale or (b) so marked as to show their proper positions.

**85.14(3) *Pivots.*** Pivots shall be made of hardened steel, except that agate may be used in prescription scales, and shall be firmly secured in position. Pivot knife-edges shall be sharp and straight and cone-pivot points shall be sharp.

**85.14(4) *Position of equipment, primary or recording indicating elements (electronic weighing elements).*** A device equipped with a primary or recording element shall be so positioned that its indications may be accurately read and the weighing operations may be observed from some reasonable "customer" position; the permissible distance between the equipment and a reasonable customer position shall be determined in each case upon the basis of individual circumstances, particularly the size and character of the indicating element; a window large enough should be placed in the building, and the installation should be so arranged as to afford an unobstructed view of the platform.

This rule is intended to implement Iowa Code section 215.18.

**21—85.15(215) *Weighbeams.*** All weighbeams, dials, or other mechanical weight-indicating elements must be placed on reinforced concrete footings or metal structural members. Concrete and metal must be of sufficient strength to keep mechanical weight-indicating elements in positive alignment with the lever system.

This rule is intended to implement Iowa Code section 215.18.

**21—85.16(215) *Beam box.*** Whenever a scale is equipped with a beam box, the beam uprights, shelf and cap must be made of channel irons or I-beams. The box covering the weighbeam may be constructed of wood or other material.

This rule is intended to implement Iowa Code section 215.18.

**21—85.17(215) *Beam rod.*** Rescinded IAB 3/31/04, effective 5/5/04.

**21—85.18(215) *Weight capacity.*** The amount of weight indicated on the beam, dial or other auxiliary weighing attachments shall not exceed the factory-rated capacity of the scale, and said capacity shall be stamped on the butt of the beam (fractional bar is not included).

**85.18(1) *Auxiliary attachment.*** If auxiliary attachment is used, the amount of the auxiliary attachment must be blocked from the beam.

**85.18(2) *Normal position.*** The normal balance position of the weighbeam of a beam scale shall be horizontal.

**85.18(3) *Travel.*** Rescinded IAB 3/31/04, effective 5/5/04.

**85.18(4) *Weighbeam.*** Rescinded IAB 3/31/04, effective 5/5/04.

**85.18(5) *Poise stop.*** Rescinded IAB 3/31/04, effective 5/5/04.

**85.18(6) *Pawl.*** Rescinded IAB 3/31/04, effective 5/5/04.

**85.18(7) *Nominal capacity, marking.*** Rescinded IAB 3/31/04, effective 5/5/04.

**85.18(8) *Uncompensated spring scales.*** A small capacity uncompensated spring scale shall be conspicuously marked to show that the scale is illegal for use in the retail sale of foodstuffs other than fruits and vegetables.

This rule is intended to implement Iowa Code section 215.16.

**21—85.19(215) *Provision for sealing coin slot.*** Provision shall be made on a coin-operated scale for applying a lead and wire seal in such a way that insertion of a coin in the coin slot will be prevented.

This rule is intended to implement Iowa Code section 215.18.

**21—85.20(215) Stock racks.** A livestock scale shall be equipped with a suitable enclosure, fitted with gates as required, within which livestock may be held on a scale platform; this rack shall be securely mounted on the scale platform and adequate clearances shall be maintained around the outside of the rack.

This rule is intended to implement Iowa Code section 215.18.

**21—85.21(215) Lengthening of platforms.** The length of the platform of a vehicle scale shall not be increased beyond the manufacturer's designed dimension except when the modification has been approved by competent scale-engineering authority, preferably that of the engineering department of the manufacturer of the scale, and by the weights and measures authority having jurisdiction over the scale.

This rule is intended to implement Iowa Code section 215.18.

**21—85.22(215) Accessibility for testing purposes.** A large capacity scale shall be so located, or such facilities for normal access thereto shall be provided that the test weights of the weights and measures official, in the denominations customarily provided, and in the amount deemed necessary by the weights and measures official for the proper testing of the scale, may readily be brought to the scale by the customary means; otherwise it shall be the responsibility of the scale owner or operator to supply such special facilities, including necessary labor, as may be required to transport the test weights to and from the scale, for testing purposes, as required by the weights and measures official.

This rule is intended to implement Iowa Code section 215.10.

**21—85.23(215) Assistance in testing operations.** If the design, construction or location of a large-capacity scale is such as to require a testing procedure involving special accessories or an abnormal amount of handling of test weights, such accessories or needed assistance in the form of labor shall be supplied by the owner or operator of the scale, as required by the weights and measures official.

This rule is intended to implement Iowa Code section 215.1A.

**21—85.24(215) Beam scale.** One on which the weights of loads of various magnitude are indicated solely by means of one or more weighbeam bars either alone or in combination with counterpoise weights.

This rule is intended to implement Iowa Code section 215.18.

**21—85.25(215) Spring scale.** An automatic-indicating scale in which the counterforce is supplied by an elastic body or system of such bodies, the shape or dimensions of which are changed by applied loads. A "compensated" spring scale is one equipped with a device intended to compensate for changes in the elasticity of the spring or springs resulting from changes in temperature, or one so constructed as to be substantially independent of such changes; an "uncompensated" spring scale is one not so equipped or constructed. A "straight-face" spring scale is one in which the indicator is affixed to the spring without intervening mechanism and which indicates weight values on a straight graduated reading-face. (The use in a scale of metal bands or strips in lieu of pivots and bearings does not constitute the scale a "spring" scale.)

This rule is intended to implement Iowa Code section 215.18.

**21—85.26(215) Weighbeam or beam.** An element comprising one or more bars equipped with movable poises or means for applying counterpoise weights or both.

This rule is intended to implement Iowa Code section 215.18.

**21—85.27(215) Livestock scale.** For purposes of the application of requirements for SR tolerances and minimum graduations, a scale having a nominal capacity of 6,000 pounds or more and used primarily for weighing livestock standing on the scale platform. (An "animal scale" is a scale adapted to weighing single heads of livestock.)

This rule is intended to implement Iowa Code section 215.18.

## SCALES

**21—85.28(215) Wheel-load weighers and axle-load scales.** The requirements for wheel-load weighers and axle-load scales apply only to such scales in official use for the enforcement of traffic in highway laws or for the collection of statistical information by government agencies.

This rule is intended to implement Iowa Code 215A.3.

**21—85.29(215) Highway vehicle.** Rescinded IAB 3/31/04, effective 5/5/04.

**21—85.30 to 85.32** Reserved.

## MEASURES

**21—85.33(214A,208A) Motor fuel and antifreeze tests and standards.** In the interest of uniformity, the tests and standards for motor fuel, including but not limited to renewable fuels such as ethanol blended gasoline, biodiesel, biodiesel blended fuel, and components such as an oxygenate, raffinate natural gasoline and motor vehicle antifreeze shall unless otherwise required by statute be those established by the American Society for Testing and Materials (ASTM) in effect on July 1, 2013, with the exception of ASTM D4814-13 for the distillation of gasoline for ethanol blended gasoline classified as higher than E-10 and up to E-50. Diesel fuel which does not comply with ASTM international specifications may be blended with biodiesel, additives or other diesel fuel so that the finished blended product does meet the applicable specifications. In addition, a motor fuel that contains more than one-half of 1 percent of methyl tertiary butyl ether (MTBE) by volume shall not be sold, offered for sale, or stored in Iowa.

This rule is intended to implement Iowa Code sections 208A.5, 208A.6, 214A.2 as amended by 2013 Iowa Acts, House File 458, and 215.18.

[ARC 0953C, IAB 8/21/13, effective 9/25/13]

**21—85.34(215) Tolerances on petroleum products measuring devices.** All pumps or meters at filling stations may have a tolerance of not over five cubic inches per five gallons, minus or plus. All pumps or measuring devices of a large capacity shall have a maintenance tolerance of 50 cubic inches, minus or plus, on a 50-gallon test. Add additional one-half cubic inch tolerance per gallon over and above a 50-gallon test. Acceptance tolerances on large capacity pumps and measuring devices shall be one-half the maintenance tolerances.

This rule is intended to implement Iowa Code sections 214.2 and 215.20.

**21—85.35(215) Meter adjustment.** If a meter is found to be incorrect and also capable of further adjustment, said meter shall be adjusted, rechecked and sealed. If a seal is broken for any cause other than by a state inspector, the department of agriculture and land stewardship shall be promptly notified of same.

**85.35(1)** Companies specializing in testing and repairing gasoline and fuel oil dispensing pumps or meters, shall be registered with the division of weights and measures, upon meeting requirements set forth by the department of agriculture and land stewardship.

**85.35(2)** In accordance with the contemplated revision of National Bureau of Standards Handbook 44-4th Edition, G-UR4.4 (Replacement of Security Seal), accredited repair and testing companies shall be authorized to affix a security seal, properly marked with the identification of such company.

**85.35(3)** If a meter is found to be inaccurate, “Repair and Placing in Service” card shall be left by the inspector.

**85.35(4)** After meter has been repaired and placed in service, the “Repair and Placing in Service” card must be returned to the Iowa Department of Agriculture and Land Stewardship, Weights and Measures Division.

This rule is intended to implement Iowa Code section 215.20.

**21—85.36(215) Recording elements.** All weighing or measuring devices shall be provided with appropriate recording or indicating elements, which shall be definite, accurate and easily read under any conditions of normal operation of the device. Graduations and a suitable indicator shall be provided in connection with indications and recorded representations designed to advance continuously. Graduations shall not be required in connection with indications or recorded representations designed to advance intermittently or with indications or recorded representations of the selector type.

This rule is intended to implement Iowa Code section 215.18.

**21—85.37(215) Air eliminator.** All gasoline or oil metering devices shall be equipped with an effective air eliminator to prevent passage of air or vapor through the meter. The vent from such eliminator shall not be closed or obstructed.

This rule is intended to implement Iowa Code section 215.18.

**21—85.38(215) Delivery outlets.** No means shall be provided by which any measured liquid can be diverted from the measuring chamber of the meter or the discharge line therefrom. However, two or more delivery outlets may be installed, if automatic means is provided to ensure that liquid can flow from only one such outlet at one time, and the direction of flow for which the mechanism may be set at any time is definitely and conspicuously indicated.

This rule is intended to implement Iowa Code section 215.18.

**21—85.39(189,215) Weights and measures.**

**85.39(1)** The specifications, tolerances and regulations for commercial weighing and measuring devices, together with amendments thereto, as recommended by the National Institute of Standards and Technology and published in National Institute of Standards and Technology Handbook 44 amended or revised as of January 1, 2020, shall be the specifications, tolerances and regulations for commercial weighing and measuring devices in the state of Iowa, except as modified by state statutes, or by rules adopted and published by the Iowa department of agriculture and land stewardship and not rescinded.

**85.39(2)** The National Institute of Standards and Technology (NIST) Handbook 130, Uniform Laws and Regulations in the Areas of Legal Metrology and Fuel Quality, Handbook 133, Checking the Net Contents of Packaged Goods, and all supplements to these handbooks, as published by the National Institute of Standards and Technology amended or revised as of January 1, 2020, are adopted in their entirety by reference except as modified by state statutes, or by rules adopted and published by the Iowa department of agriculture and land stewardship.

This rule is intended to implement Iowa Code sections 189.9, 189.13, 189.17, 215.14, 215.18 and 215.23.

[ARC 8292B, IAB 11/18/09, effective 12/23/09; ARC 0953C, IAB 8/21/13, effective 9/25/13; ARC 4947C, IAB 2/26/20, effective 4/1/20; ARC 5415C, IAB 2/10/21, effective 3/17/21]

**21—85.40(215) Inspection tag or mark.** If a meter is found to be inaccurate, an appropriate “inaccurate” card and a “repair and placing in service” card shall be left with the meter.

**85.40(1)** The “inaccurate” card is to be retained by the LP-gas dealer after repair.

**85.40(2)** The “repair and placing in service” card is to be forwarded to weights and measures division of the Iowa department of agriculture and land stewardship.

This rule is intended to implement Iowa Code section 215.5.

**21—85.41(215) Meter repair.** If the meter has not been repaired within 30 days the meter will be condemned and a red condemned tag will be attached to the meter.

This rule is intended to implement Iowa Code section 215.5.

**21—85.42(215) Security seal.** In accordance with the contemplated revision of National Institute of Standards and Technology Handbook 44, Gur. 4.4 (Replacement of Security Seal), accredited repair and

testing companies shall be authorized to affix a security seal, properly marked with the identification of such company.

This rule is intended to implement Iowa Code section 215.12.

**21—85.43(215) LP-gas meter repairs.** Companies specializing in testing and repairing LP-gas meters shall be registered with the division of weights and measures as accredited repair and testing agencies upon meeting the requirements set forth by the department of agriculture and land stewardship.

This rule is intended to implement Iowa Code section 215.20.

**21—85.44(215) LP-gas delivery.** In the delivery of LP-gas by commercial bulk trucks (bobtail) across state lines, it shall be mandatory for all trucks delivering products to be equipped with a meter that has been either tested by the state of Iowa or that carries the seal of an accredited meter service and proving company.

This rule is intended to implement Iowa Code section 215.20.

**21—85.45(215) LP-gas meter registration.** The location of all LP-gas liquid meters in retail trade shall be listed, by the owner, with the department of agriculture and land stewardship.

This rule is intended to implement Iowa Code section 215.20.

**21—85.46(215) Reporting new LP-gas meters.** Upon putting a new or used meter into service in the state of Iowa, the user shall report to the weights and measures division.

This rule is intended to implement Iowa Code section 215.20.

**21—85.47** Rescinded, effective 11/27/85.

**21—85.48(214A,215) Advertisement of the price of liquid petroleum products for retail use.**

**85.48(1)** Nothing in this rule shall be deemed to require that the price per gallon or liter or any grade or kind of liquid petroleum product sold on the station premises be displayed or advertised except on the liquid petroleum metering distribution pumps.

**85.48(2)** Petroleum product retailers, if they elect to advertise the unit price of their petroleum products at or near the curb, storefront or billboard, shall display the price per gallon or liter. The advertised price shall equal the computer price settings shown on the metering pump or shall be displayed in a manner clear to the purchaser for discounts offered for cash payment.

**85.48(3)** Notwithstanding the provisions of subrule 85.48(2), cash only prices may be posted by the petroleum marketer on the following basis:

*a.* Cash only prices must be disclosed on the posted sign as “cash only” or similar unequivocal wording in lettering 3" high and ¼" in stroke when the whole number price being shown is 36" or less in height; or in lettering at least 6" high and ½" in stroke when the whole number price is more than 36" in height.

*b.* Cash prices posted or advertised must be available to all customers, regardless of type of service (e.g., full service or self-service); or grade of product (e.g., regular, unleaded, gasohol and diesel).

*c.* Cash and credit prices or discounts must be prominently displayed on the dispenser.

*d.* A chart showing applicable cash discounts expressed in terms of both the computed and posted price shall be available to the customer on the service station premises.

**85.48(4)** On all outside display signs, the whole number shall not be less than 6" in height and not less than 3/8" in stroke, and any fraction shall be at least one-third of the size of the whole number in both height and width.

**85.48(5)** The price must be complete, including taxes without any missing numerals or fractions in the price.

**85.48(6)** Price advertising signs shall identify the type of product (e.g., regular, unleaded, gasohol and diesel), in lettering at least 3" high and ¼" in stroke when the whole number price being shown is 36" or less in height, or in lettering at least 6" high and ½" in stroke when the whole number price is more than 36" in height.

**85.48(7)** A price advertising sign shall display, if in liters and may display if in gallons, the unit measure at least in letters of 3" minimum.

**85.48(8)** Directional or informational signs for customer location of the type of service or product advertised shall be clearly and prominently displayed on the station premises in a manner not misleading to the public.

**85.48(9)** The advertising of other commodities or services offered for sale by petroleum retailers in such a way as to mislead the public with regard to petroleum product pricing shall be prohibited.

**85.48(10)** Weights and measures motor vehicle fuels decals. All motor vehicle fuel kept, offered or exposed for sale or sold at retail containing over 1 percent ethanol by volume shall be identified with a decal located on front of the motor vehicle fuel pump and placed between 30" and 50" above the driveway level or in an alternative location approved by the department. The appearance of the decal shall conform to the following standards adopted by the renewable fuels and coproducts advisory committee:

- a. The minimum design size of department-approved decals is 1.25" by 2.5".
- b. Labels may have the word "with" and shall have the name of the renewable fuel.
- c. Rescinded IAB 6/8/16, effective 7/13/16.
- d. All ethanol fuel pump stickers shall be replaced by department-approved "American Ethanol" fuel pump decals effective January 1, 2018.
- e. Biodiesel fuel containing 5 percent or less of biodiesel does not require the biodiesel label.
- f. Biodiesel fuel containing more than 5 percent but not more than 20 percent of renewable fuel must indicate on the label whether biodiesel or biomass-based diesel is the renewable fuel contained in the product. The label must also indicate that the fuel contains biodiesel or biomass-based diesel in quantities greater than 5 percent but not more than 20 percent. A specific blend percentage is not required on the label.

g. Biodiesel fuel containing more than 20 percent renewable fuel must indicate on the label whether biodiesel or biomass-based diesel is the renewable fuel contained in the product. The label must also reflect the specific percentage of biodiesel or biomass-based diesel in the product.

**85.48(11)** Ethanol blended gasoline classified as higher than E-15 shall have a department-approved visible, legible flex fuel vehicle sticker on the pump or pump handle. The updated decals need to be in place by January 1, 2018.

**85.48(12)** Ethanol blended gasoline classified as higher than E-10 and up to E-15 shall have on the pump the federal sticker required by the Environmental Protection Agency in 40 CFR Part 80 published August 25, 2011.

**85.48(13)** Ethanol blended gasoline classified with an octane rating of 87 or higher may be labeled or advertised as "super" or "plus."

**85.48(14)** Octane rating of fuel offered for sale shall be posted on the pump in a conspicuous place. The octane rating shall be posted for registered fuels. No octane rating shall be posted on the pump for ethanol blended gasoline classified as higher than E-15. The minimum octane rating for gasoline offered for sale by a retail dealer is 87 for regular grade gasoline and 90 for premium grade gasoline.

**85.48(15)** Any gasoline labeled as "leaded" shall be produced with the use of any lead additive or contain more than 0.05 grams of lead per gallon or more than 0.005 grams of phosphorus per gallon. As used in this subrule, "lead additive" means any substance containing lead or lead compounds.

**85.48(16)** Ethanol blended gasoline shall be designated E-xx where "xx" is the volume percent of ethanol in the ethanol gasoline. Ethanol blended gasoline formulated with a percentage of ethanol between 70 and 85 percent by volume shall be designated as E-85. Biodiesel fuel shall be designated as B-xx where "xx" is more than 20 percent renewable fuel by volume.

**85.48(17)** A wholesale dealer selling ethanol blended gasoline or biodiesel fuel to a purchaser shall provide the purchaser with a statement indicating the actual volume percentage present. The statement may be on the sales slip provided or a similar document such as a bill of lading or invoice. This statement shall include the specific amount of biodiesel, even if the amount of renewable fuel is 5 percent or less.

This rule is intended to implement Iowa Code sections 214A.3, 214A.16 and 215.18.

[ARC 7628B, IAB 3/11/09, effective 4/15/09; ARC 8434B, IAB 12/30/09, effective 2/3/10; ARC 0079C, IAB 4/4/12, effective 3/16/12; ARC 0953C, IAB 8/21/13, effective 9/25/13; ARC 2577C, IAB 6/8/16, effective 7/13/16]

**21—85.49(214A,215) Gallonage determination for retail sales.** The method of determining gallonage on gasoline or diesel motor vehicle fuel for retail sale shall be on a gross volume basis. Temperature correction or any deliberate methods of heating shall be prohibited.

This rule is intended to implement Iowa Code sections 214A.3 and 215.18.

**21—85.50(214,214A,215) Blender pumps.** Motor fuel blender pumps or blender pumps installed or modified after November 1, 2008, which sell both ethanol blended gasoline classified as higher than E-15 and gasoline need to have at least two hoses per pump.

This rule is intended to implement Iowa Code section 214A.2.  
[ARC 7628B, IAB 3/11/09, effective 4/15/09; ARC 0079C, IAB 4/4/12, effective 3/16/12]

**21—85.51** Reserved.

#### MOISTURE-MEASURING DEVICES

**21—85.52(215A) Testing devices.** All moisture-measuring devices will be tested against a measuring device which will be furnished by the department and all moisture-measuring devices will be inspected to determine whether they are in proper operational condition and supplied with the proper accessories.

This rule is intended to implement Iowa Code section 215A.2.

**21—85.53(215A) Rejecting devices.** Moisture-measuring devices may be rejected for any of the following reasons:

**85.53(1)** The moisture-measuring device tested is found to be out of tolerance with the measuring device used by the department by one of the inspectors so assigned by more than 0.7 percent on grain moisture content.

**85.53(2)** The person does not have available the latest charts for type of device being used.

**85.53(3)** The person does not have available the proper scale or scales and thermometers for use with the type of device being used.

**85.53(4)** The moisture-measuring device is not free from excessive dirt, debris, cracked glass or is not kept in good operational condition at all times.

This rule is intended to implement Iowa Code section 215A.6.

**21—85.54(215,215A) Specifications and standards for moisture-measuring devices.** The specifications and tolerances for moisture-measuring devices are those established by the United States Department of Agriculture as of November 15, 1971, in chapter XII of GR instruction 916-6, equipment manual, used by the federal grain inspection service; and those recommended by National Bureau of Standards and published in National Bureau of Standards Handbook 44 as of July 1, 1985.

This rule is intended to implement Iowa Code section 215A.3.

**21—85.55** Renumbered as 55.28(215), IAC 12/4/85.

**21—85.56** Renumbered as 55.29(215), IAC 12/4/85.

**21—85.57(215) Testing high-moisture grain.** When testing high-moisture grain the operator of a moisture-measuring device shall use the following procedure: Test each sample six times adding the six measurements thus obtained and dividing the total by six to obtain an average which shall be deemed to be the moisture content of such sample.

This rule is intended to implement Iowa Code section 215A.7.

**21—85.58 to 85.62** Reserved.

## HOPPER SCALES

**21—85.63(215) Hopper scales.** A “hopper scale” is a scale designed for weighing bulk commodities whose load-receiving element is a tank, box, or hopper mounted on a weighing element; and includes automatic hopper scales, grain hopper scales, and construction material hopper scales.

**85.63(1) Installation.** A hopper scale used for commercial purposes shall be so located, or such facilities for normal access thereto shall be so provided that the test weights of the weights and measures official, in the denominations customarily provided, and in the amount deemed necessary by the weights and measures official for the proper testing of the scale, may readily be brought to the scale by customary means; otherwise it shall be the responsibility of the scale owner or operator to supply such special facilities, as required by the weights and measures official. The hopper scale shall have extended angle irons with hooks 14 inches from edge to hopper, in all four corners, to allow the inspector to hook his chain and binder to 500# weight (or 1000# weight) for testing.

**85.63(2) Method of hopper scale testing.** The method to be used in testing the scale for weighing accuracy shall be by the suspension of standard test weights at each corner of the weighbridge, suspended from a point as near as possible over the center of the main bearing. A suitable permanent device to which the suspension equipment may be connected shall be properly located and placed on each corner of the weighbridge. There is to be no obstruction, such as machinery, spouting or insufficient wall clearance, etc., that will interfere with the free suspension of the weights.

**85.63(3) Approved by department.** Newly installed hopper scales must be approved by the department; this approval shall be based upon blueprints and specifications submitted for this purpose.

This rule is intended to implement Iowa Code sections 215.10 and 215.18.

[IDR 1952, p.20, 1954, 1958, 1962]

[Amended 11/18/63, 9/14/65, 12/14/65, 11/21/66, 11/15/67, 8/30/68, 9/10/69,  
9/22/69, 9/15/70, 12/17/71, 3/15/73, 7/10/74]

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[Filed 3/5/04, Notice 1/7/04—published 3/31/04, effective 5/5/04]

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[Filed emergency 4/8/08—published 5/7/08, effective 4/8/08]

[Filed ARC 7628B (Notice ARC 7370B, IAB 11/19/08), IAB 3/11/09, effective 4/15/09]

[Filed ARC 8292B (Notice ARC 8092B, IAB 9/9/09), IAB 11/18/09, effective 12/23/09]  
[Filed ARC 8434B (Notice ARC 8041B, IAB 8/12/09), IAB 12/30/09, effective 2/3/10]  
[Filed Emergency After Notice ARC 0079C (Notice ARC 9757B, IAB 9/21/11), IAB 4/4/12, effective  
3/16/12]  
[Filed ARC 0953C (Notice ARC 0815C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]  
[Filed ARC 2577C (Notice ARC 2479C, IAB 3/30/16), IAB 6/8/16, effective 7/13/16]  
[Filed ARC 4947C (Notice ARC 4844C, IAB 1/1/20), IAB 2/26/20, effective 4/1/20]  
[Filed ARC 5415C (Notice ARC 5108C, IAB 7/29/20), IAB 2/10/21, effective 3/17/21]



CHAPTER 13  
ISSUANCE OF TEACHER LICENSES AND ENDORSEMENTS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 14]

**282—13.1(272) All applicants desiring Iowa licensure.**

**13.1(1) Licenses, authorizations, certificates, and statements of professional recognition.** Licenses, authorizations, certificates, and statements of professional recognition are issued upon application filed on a form provided by the board of educational examiners and upon completion of the following:

*a. National criminal history background check.* An initial applicant will be required to submit a completed fingerprint packet that accompanies the application to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet will be assessed to the applicant.

*b. Iowa division of criminal investigation background check.* An Iowa division of criminal investigation (DCI) background check will be conducted on initial applicants. The fee for the evaluation of the DCI background check will be assessed to the applicant.

*c. Registries and records check.* A check of the following registries and records will be conducted on initial applicants: the sex offender registry under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, the central registry for dependent adult abuse information maintained under Iowa Code chapter 235B, and the information in the Iowa court information system available to the general public. The fee for checks of these registries and records will be assessed to the applicant.

**13.1(2) Temporary permits.** The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application; determination that the applicant meets all applicable prerequisites for issuance of the license, certification, or authorization; and satisfactory evaluation of the Iowa criminal history background check and registries and records check set forth in 13.1(1)“b” and “c.” The temporary permit shall serve as evidence of the applicant’s authorization to hold a position in Iowa schools, pending the satisfactory completion of the national criminal history background check. The temporary permit shall expire upon issuance of the requested license, certification, or authorization or 90 days from the date of issuance of the permit, whichever occurs first, unless the temporary permit is extended upon a finding of good cause by the executive director.

[ARC 0563C, IAB 1/23/13, effective 1/1/13; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 3633C, IAB 2/14/18, effective 3/21/18]

**282—13.2(272) Applicants from recognized Iowa institutions.** Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

**282—13.3(272) Applicants from non-Iowa institutions.** Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

**282—13.4(272) Applicants from foreign institutions.** Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

**282—13.5(272) Teacher licenses.** A license may be issued to an applicant who fulfills the general requirements set out in subrule 13.5(1) and the specific requirements set out for each license.

**13.5(1) General requirements.** The applicant shall:

- a.* Have a baccalaureate degree from a regionally accredited institution.
- b.* Have completed a state-approved teacher education program.
- c.* Have completed the teacher preparation coursework set forth in 281—subrules 79.15(2) to 79.15(5).
- d.* Have completed student teaching in the subject area and grade level endorsement desired.
- e.* Have completed the requirements for one of the basic teaching endorsements.
- f.* Provide a recommendation for the specific license and endorsement(s) from the designated recommending official at the recognized institution where the preparation was completed.

**13.5(2) Applicants from non-Iowa institutions.****a. Definitions.**

“*Nontraditional*” means any method of teacher preparation that falls outside the traditional method of preparing teachers, that provides at least a one- or two-year sequenced program of instruction taught at regionally accredited and state-approved colleges or universities, that includes commonly recognized pedagogy classes being taught for course credit, and that requires a student teaching component.

“*Proficiency*,” for the purposes of paragraph 13.5(2)“*e*,” means that an applicant has passed all parts of the standard.

“*Recognized non-Iowa teacher preparation institution*” means an institution that is state-approved and is accredited by the regional accrediting agency for the territory in which the institution is located.

**b.** In addition to the requirements set forth in subrule 13.5(1), an applicant from a non-Iowa institution:

(1) Shall submit a copy of a valid or expired regular teaching certificate or license exclusive of a temporary, emergency or substitute license or certificate.

(2) Shall provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education if the teacher preparation program was completed on or after January 1, 2013, and the applicant has verified fewer than three years of valid out-of-state teaching experience. If the teacher preparation program was completed prior to January 1, 2013, or if the applicant has verified three years of valid out-of-state teaching experience, the applicant must provide verification of successfully passing the mandated assessment(s) in the state in which the applicant is currently licensed (or verify highly qualified status) or must provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education.

(3) Shall provide an official institutional transcript(s) to be analyzed for the requirements necessary for Iowa licensure. An applicant must have completed at least 75 percent of the coursework as outlined in 281—subrules 79.15(2) to 79.15(5) and an endorsement requirement through a two- or four-year institution in order for the endorsement to be included on the license. An applicant who has not completed at least 75 percent of the coursework for at least one of the basic Iowa teaching endorsements completed will not be issued a license. An applicant seeking a board of educational examiners transcript review must have achieved a C- grade or higher in the courses that will be considered for licensure. An applicant who has met the minimum coursework requirements in this subrule will not be subject to additional coursework deficiency requirements if the applicant provides verification of ten years of successful teaching experience or if the applicant provides verification of five years of successful experience and a master’s degree.

(4) Shall demonstrate recency of experience by providing verification of either one year of teaching experience or six semester hours of college credit during the five-year period immediately preceding the date of application.

(5) Shall not be subject to any pending disciplinary proceedings in any state or country.

(6) Shall comply with all requirements with regard to application processes and payment of licensure fees.

**c.** If through a transcript analysis, the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5) or one of the basic teaching endorsement requirements for Iowa is not met, the applicant may be eligible for the equivalent Iowa endorsement areas, as designated by the Iowa board of educational examiners, based on current and valid National Board Certification.

**d.** If the teacher preparation program was considered nontraditional, candidates will be asked to verify the following:

(1) That the program was for secondary education;

(2) A cumulative grade point average of 2.50 on a 4.0 scale from a regionally accredited institution; and

(3) The completion of a student teaching or internship experience or three years of teaching experience.

*e.* If the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5) cannot be reviewed through a traditional transcript evaluation, a portfolio review and evaluation process may be utilized.

(1) An applicant must demonstrate proficiency in a minimum of at least 75 percent of the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5).

(2) An applicant must meet with the board of educational examiners to answer any of the board's questions concerning the portfolio.

*f.* An applicant under this subrule or subrule 13.5(3) shall be granted an Iowa teaching license and will not be subject to additional assessments or coursework deficiencies if the following additional requirements have been met:

(1) Verification of Iowa residency, or, for military spouses, verification of a permanent change of military installation.

(2) Valid or expired regular teaching certificate or license in good standing from another state without pending disciplinary action, valid for a minimum of one year, exclusive of a temporary, emergency or substitute license or certificate. Endorsements shall be granted based on comparable Iowa endorsements, and endorsement requirements may be waived in order to grant the most comparable endorsement.

(3) Passing test scores for the required assessments for the state where the teaching license was issued.

*g.* Holders of an Iowa regional exchange license issued prior to January 1, 2021, may submit a new application if the requirements in this subrule would have been met at the time of their initial application.

**13.5(3) *Applicants from foreign institutions.*** An applicant for initial licensure whose preparation was completed in a foreign institution must additionally obtain a course-by-course credential evaluation report completed by one of the board-approved credential evaluation services and then file this report with the Iowa board of educational examiners for a determination of eligibility for licensure. After receiving the notification of eligibility by the Iowa board of educational examiners, the applicant must provide verification of successfully passing the Iowa-mandated assessment(s) pursuant to subparagraph 13.5(2) “b”(2).

[ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2584C, IAB 6/22/16, effective 7/27/16; ARC 3829C, IAB 6/6/18, effective 7/11/18; ARC 5321C, IAB 12/16/20, effective 1/20/21]

**282—13.6(272) Specific requirements for an initial license.** An initial license valid for a minimum of two years with an expiration date of June 30 may be issued to an applicant who meets the general requirements set forth in rule 282—13.5(272).

**13.6(1)** For an applicant applying pursuant to subrule 13.5(1), a nonrenewable temporary initial license may be issued if the applicant presents an assessment waiver issued by the director of the Iowa department of education within 30 days of the waiver issuance. The applicant must meet the assessment requirement in order to apply for full Iowa licensure.

**13.6(2)** For an applicant applying pursuant to subrule 13.5(2), a nonrenewable temporary initial license may be issued to the applicant if all requirements have been met with the exception of the assessments pursuant to subparagraph 13.5(2) “b”(2). The applicant must meet the assessment requirement in order to apply for full Iowa licensure.

**13.6(3)** The temporary initial license shall be valid for one year from the date of issuance. This license is nonrenewable and may not be extended. This license may only be issued if the applicant provides an affidavit from the administrator of an Iowa school district or accredited nonpublic school verifying that an offer of a teaching contract has been made and that the employer made every reasonable and good-faith effort to employ a fully licensed teacher for the specified subject and was unable to employ such a teacher.

[ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 3979C, IAB 8/29/18, effective 10/3/18; ARC 4621C, IAB 8/28/19, effective 8/7/19]

**282—13.7(272) Specific requirements for a standard license.** A standard license valid for five years may be issued to an applicant who:

1. Meets the general requirements set forth in rule 282—13.5(272), and
2. Shows evidence of successful completion of a state-approved mentoring and induction program or mentoring through a state-approved career, leadership, and compensation framework by meeting the Iowa teaching standards as determined by a comprehensive evaluation and two years' successful teaching experience within the applicant's approved endorsement area(s). In lieu of completion of an Iowa state-approved mentoring program, the applicant must provide evidence of three years' successful teaching experience within the applicant's approved endorsement area(s) at any of the following:
  - An accredited nonpublic school in this state.
  - A preschool program approved by the United States Department of Health and Human Services.
  - Preschool programs at school districts approved to participate in the preschool program under Iowa Code chapter 256C.
  - Shared visions programs receiving grants from the child development coordinating council under Iowa Code section 256A.3.
  - Preschool programs receiving moneys from the school ready children grants account of the early childhood Iowa fund created in Iowa Code section 256I.11.
  - An out-of-state PK-12 educational setting.

[ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2792C, IAB 11/9/16, effective 12/14/16; ARC 3634C, IAB 2/14/18, effective 3/21/18]

**282—13.8(272) Specific requirements for a master educator's license.** A master educator's license is valid for five years and may be issued to an applicant who:

1. Is the holder of or is eligible for a standard license as set out in rule 282—13.7(272), and
2. Verifies five years of successful teaching experience, and
3. Completes one of the following options:
  - Master's degree from a regionally accredited college or university in a recognized endorsement area, or
  - Master's degree from a regionally accredited college or university in curriculum, effective teaching, or a similar degree program which has a focus on school curriculum or instruction.

[ARC 1168C, IAB 11/13/13, effective 12/18/13]

**282—13.9(272) Teacher intern license.**

**13.9(1) Authorization.** The teacher intern is authorized to teach in grades 7 to 12.

**13.9(2) Term.** The term of the teacher intern license will be one school year. This license is nonrenewable.

**13.9(3) Teacher intern requirements.** A teacher intern license may be issued to an applicant who has been recommended by an institution with a state-approved intern program and who has met the background check requirements set forth in rule 282—13.1(272).

**13.9(4) Requirements to convert the teacher intern license to the initial license.** An initial license shall be issued upon application provided that the teacher intern has met the requirements as verified by the recommendation from the state-approved program.

**13.9(5) Requirements to extend the teacher intern license if the teacher intern does not complete all of the education coursework during the term of the teacher intern license.**

*a.* A one-year extension of the teacher intern license may be issued upon application provided that the teacher intern has met both of the following requirements:

- (1) Successful completion of one year of teaching experience during the teacher internship.
- (2) Verification by the recommending official at the approved teacher intern program that the teacher intern has not completed all of the coursework required for the initial license.

*b.* Only one year of teaching experience during the term of the teacher intern license or the extension of a teacher intern license may be used to convert the teacher intern license to a standard teaching license.

[ARC 8688B, IAB 4/7/10, effective 5/12/10; ARC 9925B, IAB 12/14/11, effective 1/18/12; ARC 0698C, IAB 5/1/13, effective 6/5/13; ARC 0865C, IAB 7/24/13, effective 8/28/13; ARC 1374C, IAB 3/19/14, effective 4/23/14; ARC 2016C, IAB 6/10/15, effective 7/15/15]

**282—13.10(272) Specific requirements for a Class A extension license.** A nonrenewable Class A extension license valid for one year may be issued to an individual under one of the following conditions:

**13.10(1)** *Based on an expired Iowa certificate or license, exclusive of a Class A extension or Class B license.*

*a.* The holder of an expired license, exclusive of a Class A extension or Class B license, shall be eligible to receive a Class A extension license upon application. This license shall be endorsed for the type of service authorized by the expired license on which it is based.

*b.* The holder of an expired license who is currently under contract with an Iowa educational unit (area education agency/local education agency/local school district) and who does not meet the renewal requirements for the license held shall be required to secure the signature of the superintendent or designee before the license will be issued.

**13.10(2)** *Based on a mentoring and induction program.* An applicant may be eligible for a Class A extension license if the school district, after conducting a comprehensive evaluation, recommends and verifies that the applicant shall participate in the mentoring program for a third year. No further extensions are available for this type of Class A extension license.

[ARC 7987B, IAB 7/29/09, effective 9/2/09; ARC 8134B, IAB 9/9/09, effective 10/14/09; ARC 8957B, IAB 7/28/10, effective 9/1/10; ARC 2016C, IAB 6/10/15, effective 7/15/15]

**282—13.11(272) Specific requirements for a Class B license.** A Class B license, which is valid for two years and which is nonrenewable, may be issued to an individual under the following conditions:

**13.11(1)** *Endorsement in progress.* The individual has a valid initial, standard, master educator, permanent professional, Class A extension, exchange, or professional service license and one or more endorsements but is seeking to obtain some other endorsement. A Class B license may be issued if requested by an employer and if the individual seeking to obtain some other endorsement has completed at least two-thirds of the requirements, or one-half of the content requirements in a state-designated shortage area, leading to completion of all requirements for the endorsement. A Class B license may not be issued for the driver's education endorsement.

**13.11(2)** *Program of study.* The college or university must outline the program of study necessary to meet the endorsement requirements for specified areas. This program of study must be attached to the application.

**13.11(3)** *Request for executive director decision.* If the minimum content requirements have not been met for the Class B license, a one-year executive director decision license may be issued if requested by the school district and if the school district can demonstrate that a candidate with the proper endorsement was not found after a diligent search. The executive director decision license may not be renewed and will expire on June 30 of the fiscal year in which it was issued.

**13.11(4)** *Expiration.* The Class B license will expire on June 30 of the fiscal year in which it was issued plus one year.

[ARC 7987B, IAB 7/29/09, effective 9/2/09; ARC 8133B, IAB 9/9/09, effective 10/14/09; ARC 9207B, IAB 11/3/10, effective 12/8/10; ARC 9573B, IAB 6/29/11, effective 8/3/11; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 3633C, IAB 2/14/18, effective 3/21/18]

**282—13.12(272) Specific requirements for a Class C license.** Rescinded IAB 7/29/09, effective 9/2/09.

**282—13.13(272) Specific requirements for a Class D occupational license.** Rescinded IAB 7/29/09, effective 9/2/09.

**282—13.14(272) Specific requirements for a Class E emergency extension license.** A nonrenewable license valid for one year may be issued to an individual as follows:

**13.14(1)** *Expired license.* Based on an expired Class A or Class B license, the holder of the expired license shall be eligible to receive a Class E emergency extension license upon application and submission of all required materials.

**13.14(2)** *Application.* The application process will require transcripts of coursework completed during the term of the expired license, a program of study indicating the coursework necessary to

obtain full licensure, and registration for coursework to be completed during the term of the Class E emergency extension license. The Class E emergency extension license will be denied if the applicant has not completed any coursework during the term of the Class A or Class B license unless extenuating circumstances are verified.

[ARC 7987B, IAB 7/29/09, effective 9/2/09; ARC 2016C, IAB 6/10/15, effective 7/15/15]

**282—13.15(272) Specific requirements for a Class G license.** Rescinded ARC 5321C, IAB 12/16/20, effective 1/20/21.

**282—13.16(272) Specific requirements for a substitute teacher's license.**

**13.16(1) Substitute teacher requirements.** A substitute teacher's license may be issued to an individual who has completed a teacher preparation program and been the holder of, or presently holds, or is eligible to hold, a license in Iowa.

**13.16(2) Validity.** A substitute license is valid for five years and for not more than 90 days of teaching in one assignment during any one school year. A school district administrator may file a written request with the board for an extension of the 90-day limit in one assignment on the basis of documented need and benefit to the instructional program. The board will review the request and provide a written decision either approving or denying the request.

**13.16(3) Authorization.** The holder of a substitute license is authorized to substitute teach in any school system in any position in which a regularly licensed teacher is employed except in the driver's education classroom. In addition to the authority inherent in the initial, standard, master educator, professional administrator, regional exchange, full career and technical education authorization, full native language teaching authorization, professional service license, and permanent professional licenses and the endorsement(s) held, the holder of one of these regular licenses may substitute on the same basis as the holder of a substitute license while the regular license is in effect. The executive director may grant permission for a substitute to serve outside of a substitute's regular authority under unique circumstances.

[ARC 9205B, IAB 11/3/10, effective 12/8/10; ARC 9206B, IAB 11/3/10, effective 12/8/10; ARC 0605C, IAB 2/20/13, effective 3/27/13; ARC 1324C, IAB 2/19/14, effective 3/26/14; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 5303C, IAB 12/2/20, effective 1/6/21; ARC 5321C, IAB 12/16/20, effective 1/20/21; see Delay note at end of chapter]

**282—13.17(272) Specific requirements for exchange licenses.**

**13.17(1) Teacher exchange license.**

*a.* For an applicant applying under 13.5(2), a two-year nonrenewable exchange license may be issued to the applicant under any of the following conditions:

(1) The applicant has met the minimum coursework requirements for licensure but has some coursework deficiencies. Any coursework deficiencies must be completed for college credit through a regionally accredited institution, with the exception of human relations which may be taken for licensure renewal credit through an approved provider.

(2) The applicant submits verification that the applicant has applied for and will receive the applicant's first teaching license and is waiting for the processing or printing of a valid and current out-of-state license. The lack of a valid and current out-of-state license will be listed as a deficiency.

(3) The applicant has not met the requirement for recency set forth in 13.5(2) "b"(4).

*b.* After the term of the exchange license has expired, the applicant may apply to be fully licensed if the applicant has completed all requirements and is eligible for full licensure.

**13.17(2) International teacher exchange license.**

*a.* A nonrenewable international exchange license may be issued to an applicant under the following conditions:

(1) The applicant has completed a teacher education program in another country; and

(2) The applicant is a participant in a teacher exchange program administered through the Iowa department of education, the U.S. Department of Education, or the U.S. Department of State.

*b.* Each exchange license shall be limited to the area(s) and level(s) of instruction as determined by an analysis of the application and the credential evaluation report.

c. This license shall not exceed one year unless the applicant can verify continued participation in the exchange program beyond one year.

d. After the term of the exchange license has expired, the applicant may apply to be fully licensed if the applicant has completed all requirements and is eligible for full licensure.

**13.17(3) Military exchange license.**

a. *Definitions.*

“*Military service*” means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1; in the military services of other states, as provided in 10 U.S.C. Section 101(c); or in the organized reserves of the United States, as provided in 10 U.S.C. Section 10101.

“*Veteran*” means an individual who meets the definition of “veteran” in Iowa Code section 35.1(2).

b. *Spouses of active duty military service members applying under 13.5(2).* A three-year nonrenewable military exchange license may be issued to the applicant under the following conditions:

(1) The applicant has completed a traditional teacher preparation program at a regionally accredited and state-approved two- or four-year college.

(2) The applicant is the holder of a valid and current or an expired teaching license from another state.

(3) The applicant provides verification of the applicant’s connection to or the applicant’s spouse’s connection to the military by providing a copy of current military orders with either a marriage license or a copy of a military ID card for the applicant’s spouse.

(4) This license may be converted to a one-year regional exchange license upon application and payment of fees.

c. *Veterans or their spouses applying under 13.5(2).* A three-year military exchange license may be issued to an applicant who meets the requirements of 13.17(3) “b”(1) and (2). A veteran must provide a copy of the veteran’s DD 214. A spouse must provide a copy of the veteran spouse’s DD 214 and the couple’s marriage license.

d. *Spouses of active duty military service veterans, or veterans’ spouses applying under 13.5(2).* If the applicant has completed a nontraditional teacher preparation program but is not eligible for a teaching license, the applicant will be issued a substitute license, and the initial review for the portfolio review process will be completed by board staff. An applicant must provide verification of connection to the military outlined in 13.17(3) “b”(3) or 13.17(3) “c.”

e. *Military education, training, and service credit.* An applicant for the military exchange license may apply for credit for verified military education, training, or service toward any experience or educational requirement for licensure by submitting documentation to the board of educational examiners. The applicant shall identify the experience or educational requirement to which the credit would be applied if granted. The board of educational examiners shall promptly determine whether the verified military education, training, or service will satisfy all or any part of the identified experience or educational requirement for licensure.

[ARC 8138B, IAB 9/9/09, effective 10/14/09; ARC 8604B, IAB 3/10/10, effective 4/14/10; ARC 9072B, IAB 9/8/10, effective 10/13/10; ARC 9840B, IAB 11/2/11, effective 12/7/11; ARC 0563C, IAB 1/23/13, effective 1/1/13; ARC 0868C, IAB 7/24/13, effective 8/28/13; ARC 1166C, IAB 11/13/13, effective 12/18/13; ARC 1323C, IAB 2/19/14, effective 3/26/14; ARC 1454C, IAB 5/14/14, effective 6/18/14; ARC 1878C, IAB 2/18/15, effective 3/25/15; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 3196C, IAB 7/5/17, effective 8/9/17; ARC 5304C, IAB 12/2/20, effective 1/6/21]

**282—13.18(272) General requirements for an original teaching subject area endorsement.** Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

**282—13.19(272) NCATE-accredited programs.** Rescinded IAB 6/17/09, effective 7/22/09.

**282—13.20(272) Permanent professional certificates.** Effective October 1, 1988, the permanent professional certificate will no longer be issued. Any permanent professional certificate issued prior to October 1, 1988, will continue in force with the endorsements and approvals appearing thereon, unless revoked or suspended for cause. If a permanent professional certificate is revoked and if the holder is

able at a later date to overcome or remediate the reasons for the revocation, the holder may apply for the appropriate new class of license set forth in this chapter.

[ARC 3633C, IAB 2/14/18, effective 3/21/18]

**282—13.21(272) Human relations requirements for practitioner licensure.** Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

**282—13.22(272) Development of human relations components.** Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

**282—13.23 to 13.25** Reserved.

**282—13.26(272) Requirements for elementary endorsements.**

**13.26(1) Teacher—prekindergarten-kindergarten.**

*a. Authorization.* The holder of this endorsement is authorized to teach at the prekindergarten-kindergarten level. Applicants for this endorsement must also hold the teacher—elementary classroom endorsement set forth in subrule 13.26(4) or the early childhood special education endorsement set forth in 282—subrule 14.2(1).

*b. Content.* Coursework must total a minimum of 18 semester hours and shall include the following:

(1) Child development and learning to include young children's characteristics and needs, with an emphasis on cognitive, language, physical, social, and emotional development, both typical and atypical, the multiple interacting influences on early development, and the creation of environments that are healthy, respectful, supportive, and challenging for each and every child.

(2) Building family and community relationships to include understanding that successful early childhood education depends upon reciprocal and respectful partnerships with families, communities, and agencies, that these partnerships have complex and diverse characteristics, and that all families should be involved in their children's development and learning.

(3) Assessment in early childhood to include child observation, documentation, and data collection, the development of appropriate goals, the benefits and uses of assessment for curriculum and instructional strategies, the use of technology when appropriate for assessment and adaptations, and building assessment partnerships with families to positively influence the development of each child.

(4) Developmentally effective approaches to include understanding how positive relationships and supportive interactions are the foundation of working with young children and families; knowing and understanding a wide array of developmentally appropriate approaches, including play and creativity, instructional strategies, and tools to connect with children and families; and reflecting on the teacher's own practice to promote positive outcomes for each child.

(5) Content knowledge to build a meaningful curriculum through the use of academic disciplines, including language and literacy, the arts (music, drama, dance, and visual arts), mathematics, science, social studies, physical activity, and health, for designing, implementing, and evaluating inquiry-based experiences that promote positive development and learning for each child.

(6) Collaboration and professionalism to include involvement in the early childhood field, knowledge about ethical and early childhood professional standards, engagement in continuous collaborative learning to inform practice, reflective and critical perspectives on early childhood education, and informed advocacy for young children and the profession.

(7) Field experiences and opportunities to observe and practice in a variety of early childhood settings, which include, at a minimum, 40 hours of observation and practice in a variety of preschool settings such as urban, rural, socioeconomic status, cultural diversity, program types, and program sponsorship.

(8) Historical, philosophical, and social foundations of early childhood education.

(9) Student teaching in a prekindergarten setting as required in rule 281—79.14(256).

**13.26(2) Teacher—birth through grade three, inclusive settings.**

a. *Authorization.* The holder of this endorsement is authorized to teach children from birth through grade three in inclusive settings.

b. *Content.*

(1) Promoting child development and learning and individual learning differences.

1. Understand the nature of child growth and development for infants and toddlers (birth through age 2), preprimary (age 3 through age 5) and primary school children (age 6 through age 8), both typical and atypical, in areas of cognition, language development, physical motor, social-emotional, mental health, aesthetics, and adaptive behavior and how these impact development and learning in the first years of life, including the etiology, characteristics, and classifications of common disabilities in infants and young children and specific implications for development and learning.

2. Recognize that children are best understood in the contexts of family, culture and society and that cultural and linguistic diversity, stress, risk factors, biological and environmental factors, family strengths, and trauma influence development and learning at all stages, including pre-, peri-, and postnatal development and learning. Communicate the importance of responsive care to a child's development of identity and sense of self.

3. Use developmental knowledge to create learning environments and classroom procedures that promote positive social interaction, active engagement, high expectations for learning, mutual respect, and self-regulation through individually appropriate expectations and positive guidance techniques for each child to meet the child's optimum potential regardless of proficiency. Implement and evaluate preventative and reductive strategies to address challenging behaviors. Use motivational and instructional interventions to teach individuals with exceptionalities how to adapt to different environments. Know how to intervene safely and appropriately with individuals in crisis.

4. Use both child-initiated and teacher-facilitated instructional methods, including strategies such as small and large group projects, play, systematic instruction, group discussion and cooperative decision making. Organize space, time, materials, peers, and adults to maximize progress in natural and structured environments. Embed learning opportunities in everyday routines, relationships, activities, and places. Understand the impact of social and physical environments on development and learning.

5. Engage in intentional practices and implement learning experiences that value diversity and demonstrate understanding that bias and discrimination impact development. Understand how language, culture, and family background influence and support the learning of each child.

(2) Building family and community relationships.

1. Build family and community relationships to include understanding that successful early childhood education depends upon reciprocal and respectful partnerships with families, communities, and agencies, that these partnerships have complex and diverse characteristics, and that all families should be involved in their children's development and learning.

2. Understand diverse family and community characteristics and how language, culture, and family background influence and support children's learning, and apply that knowledge to develop, implement, and evaluate learning experience and strategies that respect and reflect the diversity of children and their families.

3. Understand how to apply theories and knowledge of dynamic roles and relationships within and between families, schools, and communities. Recognize how to adapt consistently to the expressed and observed strengths and needs of the family, including two-way communication, and how to support families' choices and priorities in the development of goals and intervention strategies.

4. Understand how to coordinate with all (caregivers, professionals, and agencies) who provide care and learning opportunities for each child by developing a community of support for children and families through interagency collaboration to include agreements, referrals, and consultation.

(3) Observing, documenting, and assessing to support young children and families.

1. Use technically sound formal and informal assessments that minimize bias and evaluation results to adapt and guide instruction. Demonstrate a range of appropriate assessment and evaluation strategies (e.g., family interview, observation, documentation, assessment instrument) to support individual strengths, interests, and needs.

2. Design curricula, assessments, and teaching and intervention strategies that align with learner and program goals, including the development of individualized family service plans (IFSPs) and individualized education plans (IEPs). Assist families in identifying resources, priorities, and concerns in relation to the child's development. Understand and utilize assessment partnerships with families and with professional colleagues to build effective learning environments. Understand the role of the families in the assessment process and support the choices they make (e.g., observer, participant). Participate as a team member to integrate assessment results in the development and implementation of individualized plans.

3. Understand and utilize observation, documentation, and other appropriate assessment tools and approaches, including the use of technology in documentation, assessment and data collection. Implement authentic assessment based on observation of spontaneous play. Demonstrate knowledge of alignment of assessment with curriculum, content standards, and local, state, and federal requirements. Assess progress in the developmental domains, play, and temperament.

4. Understand and utilize responsible assessments to promote positive outcomes for each child, including the use of assistive technology for children with disabilities. Use a variety of materials and contexts to maintain the interest of infants and young children in the assessment process.

5. Implement current educational, legal, and ethical guidelines when using assessment practices to support children's individual strengths, interests, and needs (e.g., cultural, linguistic, ability diversity).

(4) Using developmentally and individually effective approaches to connect with children and families.

1. Understand positive relationships and supportive interactions as the foundation of the teacher's work with young children. Reflect on the teacher's own practice to promote positive outcomes for each child and family.

2. Develop, implement, and evaluate individualized plans, including IFSPs and IEPs, as a team leader with families and other professionals. Demonstrate appropriate and effective supports for children and families transitioning into and out of programs or classrooms. Seek and use additional resources and agencies outside the program/school when needed to effectively facilitate the learning and social/emotional development of each child.

3. Plan, develop, implement, and evaluate integrated learning experiences for home-, center- and school-based environments for infants, toddlers, preprimary and primary children, their families, and other care providers based on knowledge of individual children, the family, and the community. Select, develop, and evaluate developmentally and functionally appropriate materials, equipment, and environments. Develop adaptations and accommodations for infants, toddlers, preprimary, and primary children to meet their individual needs. Use a broad repertoire of developmentally and individually appropriate teaching/learning approaches and effective strategies and tools for early education, including appropriate uses of technology. Facilitate child-initiated development and learning.

4. Consider an individual's abilities, interests, learning environments, and cultural and linguistic factors in the selection, development, and adaptation of learning experiences for individuals with exceptionalities. Use teacher-scaffolded and -initiated instruction to complement child-initiated learning. Link development, learning experiences, and instruction to promote educational transitions. Use individual and group guidance and problem-solving techniques to develop supportive relationships with and among children. Use strategies to teach social skills and conflict resolution.

5. Implement basic health, nutrition, and safety management procedures, including the design of physically and psychologically safe and healthy indoor and outdoor environments to promote development and learning. Recognize signs of emotional distress, physical and mental abuse and neglect in young children and understand mandatory reporting procedures. Demonstrate proficiency in infant-child cardiopulmonary resuscitation, emergency procedures and first aid.

6. Understand principles of administration, organization, and operation of programs for children from birth to age 8 and their families, including staff and program development, supervision, evaluation of staff, and continuing improvement of programs and services. Employ adult learning principles in consulting with and training family members and service providers.

7. Demonstrate the ability to collaborate with general educators and other colleagues to create safe, inclusive, culturally responsive learning environments to engage individuals with exceptionalities and diverse abilities in meaningful learning activities and social interactions.

(5) Using content knowledge to build a meaningful curriculum.

1. Develop and implement appropriate current research-supported learning experiences with a focus on the developmental domains, play, temperament, language and literacy to include first (home) and second language acquisition, mathematics, science, the arts (music, visual art, and drama), physical activity, health and safety, social studies, social skills, higher-thinking skills, and developmentally and individually appropriate methodology. Methods courses are required for the following areas: literacy, mathematics, social studies, science, physical education and wellness, and visual and performing arts.

2. Use the Iowa Early Learning Standards and the Iowa core with information from ongoing child observations and assessments to plan, implement, and evaluate appropriate instruction that improves academic and developmental progress of each child, including those with IFSPs/IEPs.

3. Understand the central concepts, structures of the discipline, and tools of inquiry of content areas taught, and demonstrate the ability to organize this knowledge, integrate cross-disciplinary skills, and develop meaningful learning progressions for individuals with exceptionalities (diverse abilities).

4. Modify general and specialized curricula to make them accessible to individuals with exceptionalities (diverse abilities). Develop adaptations and accommodations for infants, toddlers, preprimary, and primary children to meet their individual needs.

(6) Professional responsibilities.

1. Demonstrate awareness of early childhood program criteria, including the following: National Association for the Education of Young Children (NAEYC), Iowa Early Learning Standards, Head Start Performance Standards, and Iowa Quality Preschool Program Standards (IQPPS).

2. Collaborate with supervisors, mentors, and colleagues to enhance professional growth within and across disciplines to inform practice, including the use of data for decision making, and understand how to design and implement a professional development plan based on student achievement, self, peer, and supervisory evaluations and recommended practices.

3. Understand the significance of lifelong learning and participate in professional activities and learning communities. Participate in activities of professional organizations relevant to early childhood regular education, special education, and early intervention.

4. Use relevant national and state professional guidelines (national, state, or local), state curriculum standards, and current trends for content and outcomes and to inform and improve practices for young children and their families.

5. Adhere to state and national professional and ethical principles, practices, and codes.

6. Advocate for developmentally and individually appropriate practice, demonstrate awareness of issues that affect the lives of each child, and demonstrate necessary communication skills.

7. Understand historical, philosophical and foundational knowledge and how current issues and the legal bases of services influence professional practice in early childhood, early intervention, early childhood special education, and general and regular education in the K-3 age groups. Understand trends and issues in early childhood education, early childhood special education, and early intervention.

8. Provide guidance and direction to paraeducators, tutors, and volunteers.

(7) Early childhood field experiences.

1. Pre-student teaching field experiences, which must comprise a minimum of 100 clock hours, to include at least 20 hours of working with each age group (infants and toddlers, preprimary, and primary).

2. Experiences working in at least three settings that offer early childhood education, such as approved child care centers and registered child development homes, school-based preschool, community agencies, or home visiting programs.

3. Experiences working with children who have a range of abilities and disabilities and who reflect diverse family systems and other differentiating factors, such as urban and rural, socioeconomic status, and cultural and linguistic diversity.

4. Completion of supervised student teaching experience in at least two different settings including registered child development homes, home visiting programs, state-accredited child care centers, or

classrooms which include both children with and without disabilities in two of three age levels: infant and toddler, preprimary, and primary.

**13.26(3) Teacher—prekindergarten through grade three, including special education.** Rescinded IAB 7/5/17, effective 8/9/17.

**13.26(4) Teacher—elementary classroom.**

*a. Authorization.* The holder of this endorsement is authorized to teach in kindergarten and grades one through six.

*b. Content.*

(1) Child growth and development with emphasis on the emotional, physical and mental characteristics of elementary age children, unless completed as part of the professional education core.

(2) At least 9 semester hours in literacy development, which must include:

1. Content:

- Oral and written communication development; and linguistics, including phonology and phonological awareness, sound-symbol association, syllable types, morphology, syntax and semantics, and the relationship of these components to typical and atypical reading development and reading instruction;

- Phonemic awareness;

- Word identification, including phonics and orthography;

- Fluency;

- Vocabulary;

- Comprehension;

- Writing mechanics;

- Writing conventions;

- Writing process;

- Children's literature.

2. Methods:

- Assessment, diagnosis and evaluation of student learning in literacy, including the knowledge of the signs and symptoms of dyslexia and other reading difficulties;

- Integration of the language arts (to include reading, writing, speaking, viewing, and listening);

- Integration of technology in teaching and student learning in literacy;

- Current best-practice, research-based strategies and instructional technology for designing and delivering effective instruction, including appropriate interventions, groupings, remediation, assistive technology, and classroom accommodations for all students including students with dyslexia and other difficulties;

- Classroom management as it applies to literacy methods;

- Pre-student teaching clinical experience in teaching literacy.

(3) At least 9 semester hours in mathematics which must include:

1. Content:

- Numbers and operations;

- Algebra/number patterns;

- Geometry;

- Measurement;

- Data analysis/probability.

2. Methods:

- Assessment, diagnosis and evaluation of student learning in mathematics;

- Current best-practice, research-based instructional methods in mathematical processes (to include problem solving; reasoning; communication; the ability to recognize, make and apply connections; integration of manipulatives; the ability to construct and to apply multiple connected representations; and the application of content to real world experiences);

- Integration of technology in teaching and student learning in mathematics;

- Classroom management as it applies to mathematics methods;

- Pre-student teaching clinical experience in teaching mathematics.

- (4) At least 9 semester hours in social sciences which must include:
1. Content:
    - History;
    - Geography;
    - Political science/civic literacy;
    - Economics;
    - Behavioral sciences.
  2. Methods:
    - Current best-practice, research-based approaches to the teaching and learning of social sciences;
    - Integration of technology in teaching and student learning in social sciences;
    - Classroom management as it applies to social science methods.
- (5) At least 9 semester hours in science which must include:
1. Content:
    - Physical science;
    - Earth/space science;
    - Life science.
  2. Methods:
    - Current best-practice, research-based methods of inquiry-based teaching and learning of science;
    - Integration of technology in teaching and student learning in science;
    - Classroom management as it applies to science methods.
- (6) At least 3 semester hours to include all of the following:
1. Methods of teaching elementary physical education, health, and wellness;
  2. Methods of teaching visual arts for the elementary classroom;
  3. Methods of teaching performance arts for the elementary classroom.
- (7) Pre-student teaching field experience in at least two different grade levels to include one primary and one intermediate placement.
- (8) A field of specialization in a single discipline or a formal interdisciplinary program of at least 12 semester hours.
- (9) Student teaching in an elementary general education classroom.
- [ARC 8400B, IAB 12/16/09, effective 1/20/10; ARC 8401B, IAB 12/16/09, effective 1/20/10; ARC 8402B, IAB 12/16/09, effective 1/20/10; ARC 8607B, IAB 3/10/10, effective 4/14/10; ARC 0446C, IAB 11/14/12, effective 12/19/12; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2527C, IAB 5/11/16, effective 6/15/16; ARC 2584C, IAB 6/22/16, effective 7/27/16; ARC 3197C, IAB 7/5/17, effective 8/9/17]

## 282—13.27(272) Requirements for middle school endorsements.

**13.27(1) Authorization.** The holder of this endorsement is authorized to teach in the two concentration areas in which the specific requirements have been completed as well as in other subject areas in grades five through eight which are not the core content areas. The holder is not authorized to teach art, industrial arts, music, reading, physical education, talented and gifted, English as a second language, and special education.

### 13.27(2) Program requirements.

*a.* Be the holder of a currently valid Iowa teacher's license with either the general elementary endorsement or one of the subject matter secondary level endorsements set out in rule 282—13.28(272).

*b.* A minimum of 9 semester hours of required coursework in the following:

(1) Coursework in the growth and development of the middle school age child, specifically addressing the social, emotional, physical and cognitive characteristics and needs of middle school age children in addition to related studies completed as part of the professional education core.

(2) Coursework in middle school design, curriculum, instruction, and assessment including, but not limited to, interdisciplinary instruction, teaming, and differentiated instruction in addition to related studies completed as part of the professional education core.

(3) Coursework to prepare middle school teachers in literacy (reading, writing, listening and speaking) strategies for students in grades five through eight and in methods to include these strategies throughout the curriculum.

c. Thirty hours of middle school field experiences included in the coursework requirements listed in 13.27(2)“b”(1) to (3).

**13.27(3) Concentration areas.** To obtain this endorsement, the applicant must complete the coursework requirements in two of the following content areas:

a. *Social studies concentration.* The social studies concentration requires 12 semester hours of coursework in social studies to include coursework in United States history, world history, government and geography.

b. *Mathematics concentration.* The mathematics concentration requires 12 semester hours in mathematics to include coursework in algebra.

c. *Science concentration.* The science concentration requires 12 semester hours in science to include coursework in life science, earth science, and physical science.

d. *Language arts concentration.* The language arts concentration requires 12 semester hours in language arts to include coursework in composition, language usage, speech, young adult literature, and literature across cultures.

[ARC 2016C, IAB 6/10/15, effective 7/15/15]

**282—13.28(272) Minimum content requirements for teaching endorsements.**

**13.28(1) Agriculture.** 5-12. Completion of 24 semester credit hours in agriculture and agriculture education to include:

a. Foundations of vocational and career education.

b. Planning and implementing courses and curriculum.

c. Methods and techniques of instruction to include evaluation of programs and students.

d. Coordination of cooperative education programs.

e. Coursework in each of the following areas and at least three semester credit hours in five of the following areas:

(1) Agribusiness systems.

(2) Power, structural, and technical systems.

(3) Plant systems.

(4) Animal systems.

(5) Natural resources systems.

(6) Environmental service systems.

(7) Food products and processing systems.

**13.28(2) Art.** K-8 or 5-12. Completion of 24 semester hours in art to include coursework in art history, studio art, and two- and three-dimensional art.

**13.28(3) Business—all.** 5-12. Completion of 30 semester hours in business to include 6 semester hours in accounting, 3 semester hours in business law to include contract law, 3 semester hours in computer and technical applications in business, 6 semester hours in marketing to include consumer studies, 3 semester hours in management, 6 semester hours in economics, and 3 semester hours in business communications to include formatting, language usage, and oral presentation. Coursework in entrepreneurship and in financial literacy may be a part of, or in addition to, the coursework listed above.

**13.28(4) Driver education.** 5-12. Completion of 9 semester hours in driver education to include coursework in accident prevention that includes drug and alcohol abuse; vehicle safety; and behind-the-wheel driving.

**13.28(5) English/language arts.**

a. *K-8.* Completion of 24 semester hours in English and language arts to include coursework in oral communication, written communication, language development, reading, children’s literature, creative drama or oral interpretation of literature, and American literature.

b. 5-12. Completion of 24 semester hours in English to include coursework in oral communication, written communication, language development, reading, American literature, English literature and adolescent literature.

**13.28(6) Language arts. 5-12.** Completion of 40 semester hours in language arts to include coursework in the following areas:

a. *Written communication.*

(1) Develops a wide range of strategies and appropriately uses writing process elements (e.g., brainstorming, free-writing, first draft, group response, continued drafting, editing, and self-reflection) to communicate with different audiences for a variety of purposes.

(2) Develops knowledge of language structure (e.g., grammar), language conventions (e.g., spelling and punctuation), media techniques, figurative language and genre to create, critique, and discuss print and nonprint texts.

b. *Oral communication.*

(1) Understands oral language, listening, and nonverbal communication skills; knows how to analyze communication interactions; and applies related knowledge and skills to teach students to become competent communicators in varied contexts.

(2) Understands the communication process and related theories, knows the purpose and function of communication and understands how to apply this knowledge to teach students to make appropriate and effective choices as senders and receivers of messages in varied contexts.

c. *Language development.*

(1) Understands inclusive and appropriate language, patterns and dialects across cultures, ethnic groups, geographic regions and social roles.

(2) Develops strategies to improve competency in the English language arts and understanding of content across the curriculum for students whose first language is not English.

d. *Young adult literature, American literature, and world literature.*

(1) Reads, comprehends, and analyzes a wide range of texts to build an understanding of self as well as the cultures of the United States and the world in order to acquire new information, to respond to the needs and demands of society and the workplace, and for personal fulfillment. Among these texts are fiction and nonfiction, graphic novels, classic and contemporary works, young adult literature, and nonprint texts.

(2) Reads a wide range of literature from many periods in many genres to build an understanding of the many dimensions (e.g., philosophical, ethical, aesthetic) of human experience.

(3) Applies a wide range of strategies to comprehend, interpret, evaluate, and appreciate texts. Draws on prior experience, interactions with other readers and writers, knowledge of word meaning and of other texts, word identification strategies, and an understanding of textual features (e.g., sound-letter correspondence, sentence structure, context, graphics).

(4) Participates as a knowledgeable, reflective, creative, and critical member of a variety of literacy communities.

e. *Creative voice.*

(1) Understands the art of oral interpretation and how to provide opportunities for students to develop and apply oral interpretation skills in individual and group performances for a variety of audiences, purposes and occasions.

(2) Understands the basic skills of theatre production including acting, stage movement, and basic stage design.

f. *Argumentation/debate.*

(1) Understands concepts and principles of classical and contemporary rhetoric and is able to plan, prepare, organize, deliver and evaluate speeches and presentations.

(2) Understands argumentation and debate and how to provide students with opportunities to apply skills and strategies for argumentation and debate in a variety of formats and contexts.

g. *Journalism.*

(1) Understands ethical standards and major legal issues including First Amendment rights and responsibilities relevant to varied communication content. Utilizes strategies to teach students about

the importance of freedom of speech in a democratic society and the rights and responsibilities of communicators.

(2) Understands the writing process as it relates to journalism (e.g., brainstorming, questioning, reporting, gathering and synthesizing information, writing, editing, and evaluating the final media product).

(3) Understands a variety of forms of journalistic writing (e.g., news, sports, features, opinion, Web-based) and the appropriate styles (e.g., Associated Press, multiple sources with attribution, punctuation) and additional forms unique to journalism (e.g., headlines, cutlines, and/or visual presentations).

*h. Mass media production.*

(1) Understands the role of the media in a democracy and the importance of preserving that role.

(2) Understands how to interpret and analyze various types of mass media messages in order for students to become critical consumers.

(3) Develops the technological skills needed to package media products effectively using various forms of journalistic design with a range of visual and auditory methods.

*i. Reading strategies (if not completed as part of the professional education core requirements).*

(1) Uses a variety of skills and strategies to comprehend and interpret complex fiction, nonfiction and informational text.

(2) Reads for a variety of purposes and across content areas.

**13.28(7) World language.** K-8 and 5-12. Completion of 24 semester hours in each world language for which endorsement is sought.

**13.28(8) Health.** K-8 and 5-12. Completion of 24 semester hours in health to include coursework in public or community health, personal wellness, substance abuse, family life education, mental/emotional health, and human nutrition. A current certificate of CPR training is required in addition to the coursework requirements.

For holders of physical education or family and consumer science endorsements, completion of 18 credit hours in health to include coursework in public or community health, personal wellness, substance abuse, family life education, mental/emotional health, and human nutrition. A current certificate of CPR training is required in addition to the coursework requirements.

**13.28(9) Family and consumer sciences—general.** 5-12. Completion of 24 semester hours in family and consumer sciences to include coursework in lifespan development, parenting and child development education, family studies, consumer resource management, textiles or apparel design and merchandising, housing, foods and nutrition, and foundations of career and technical education as related to family and consumer sciences.

**13.28(10) Industrial technology.** 5-12. Completion of 24 semester hours in industrial technology to include coursework in manufacturing, construction, energy and power, graphic communications and transportation. The coursework is to include at least 6 semester hours in three different areas.

**13.28(11) Journalism.** 5-12. Completion of 15 semester hours in journalism to include coursework in writing, editing, production and visual communications.

**13.28(12) Mathematics.**

*a. K-8.* Completion of 24 semester hours in mathematics to include coursework in algebra, geometry, number theory, measurement, computer programming, and probability and statistics.

*b. 5-12.*

(1) Completion of 24 semester hours in mathematics to include a linear algebra or an abstract (modern) algebra course, a geometry course, a two-course sequence in calculus, a computer programming course, a probability and statistics course, and coursework in discrete mathematics.

(2) For holders of the physics 5-12 endorsement, completion of 17 semester hours in mathematics to include a geometry course, a two-course sequence in calculus, a probability and statistics course, and coursework in discrete mathematics.

(3) For holders of the all science 9-12 endorsement, completion of 17 semester hours in mathematics to include a geometry course, a two-course sequence in calculus, a probability and statistics course, and coursework in discrete mathematics.

*c. 5-8 algebra for high school credit.* For a 5-8 algebra for high school credit endorsement, hold either the K-8 mathematics or middle school mathematics endorsement and complete a college algebra or linear algebra class. This endorsement allows the holder to teach algebra to grades 5-8 for high school credit.

**13.28(13) Music.**

*a. K-8.* Completion of 24 semester hours in music to include coursework in music theory (at least two courses), music history, and applied music, and a methods course in each of the following: general, choral, and instrumental music.

*b. 5-12.* Completion of 24 semester hours in music to include coursework in music theory (at least two courses), music history (at least two courses), applied music, and conducting, and a methods course in each of the following: general, choral, and instrumental music.

**13.28(14) Physical education.**

*a. K-8.* Completion of 24 semester hours in physical education to include coursework in human anatomy, human physiology, movement education, adaptive physical education, personal wellness, human growth and development of children related to physical education, and first aid and emergency care. A current certificate of CPR training is required in addition to the coursework requirements.

*b. 5-12.* Completion of 24 semester hours in physical education to include coursework in human anatomy, kinesiology, human physiology, human growth and development related to maturational and motor learning, adaptive physical education, curriculum and administration of physical education, personal wellness, and first aid and emergency care. A current certificate of CPR training is required in addition to the coursework requirements.

**13.28(15) Reading.** K-8 and 5-12. Completion of 24 semester hours in reading to include all of the following requirements:

*a. Foundations of reading.* This requirement includes the following competencies:

(1) The practitioner demonstrates knowledge of the psychological, sociocultural, motivational, and linguistic foundations of reading and writing processes and instruction.

(2) The practitioner demonstrates knowledge of a range of research pertaining to reading, writing, and learning, including the analysis of scientifically based reading research, and knowledge of histories of reading. The range of research encompasses research traditions from the fields of the social sciences and other paradigms appropriate for informing practice and also definitions of reading difficulties including but not limited to dyslexia.

(3) The practitioner demonstrates knowledge of the major components of reading, such as comprehension, vocabulary, word identification, fluency, phonics, and phonemic awareness, and effectively integrates curricular standards with student interests, motivation, and background knowledge.

*b. Reading curriculum and instruction.* This requirement includes the following competencies:

(1) The practitioner demonstrates knowledge of designing and implementing an integrated, comprehensive, and balanced curriculum that addresses the major components of reading and contains a wide range of texts, including but not limited to narrative, expository, and poetry, and including traditional print, digital, and online resources.

(2) The practitioner uses knowledge of a range of research-based strategies and instructional technology for designing and delivering effective instruction, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties.

(3) The practitioner demonstrates knowledge of grouping students, selecting materials appropriate for learners with diverse abilities at various stages of reading and writing development, differentiating instruction to meet the unique needs of all learners, including students with dyslexia, offering sufficient opportunities for students to practice reading skills, and providing frequent and specific instructional feedback to guide students' learning.

(4) The practitioner demonstrates knowledge of designing instruction to meet the needs of diverse populations, including populations in urban, suburban, and rural settings, as well as for students from various cultural and linguistic backgrounds.

(5) The practitioner demonstrates knowledge of creating a literate physical environment which is low risk, supports students as agents of their own learning, and supports a positive socio-emotional impact for students to identify as readers.

*c. Reading assessment, diagnosis and evaluation.* This requirement includes the following competencies:

(1) The practitioner understands types of reading and writing assessments and their purposes, strengths, and limitations.

(2) The practitioner demonstrates knowledge of selecting and developing appropriate assessment instruments, procedures, and practices that range from individual to group and from formal to informal to alternative for the identification, screening, and diagnosis of all students' reading proficiencies and needs including knowledge of the signs and symptoms of dyslexia and other reading difficulties.

(3) The practitioner demonstrates knowledge of assessment data analysis to inform, plan, measure, progress monitor, and revise instruction for all students and to communicate the outcomes of ongoing assessments to all stakeholders.

(4) The practitioner demonstrates awareness of policies and procedures related to special programs, including Title I.

*d. Reading in the content areas.* This requirement includes the following competencies:

(1) The practitioner demonstrates knowledge of morphology and the etymology of words, along with text structure and the dimensions of content area vocabulary and comprehension, including literal, interpretive, critical, and evaluative.

(2) The practitioner demonstrates an understanding of reading theory, reading knowledge, and a variety of research-based strategies and approaches to provide effective literacy instruction into content areas.

(3) The practitioner demonstrates knowledge of integrating literacy instruction into content areas for all students, including but not limited to students with disabilities, students who are at risk of academic failure, students who have been identified as gifted and talented, students who have limited English language proficiency, and students with dyslexia, whether or not such students have been identified as children requiring special education under Iowa Code chapter 256B.

*e. Language development.* This requirement includes the following competency: The practitioner uses knowledge of oral language development, linguistics including phonology and phonological awareness, sound-symbol association, syllable types, morphology, syntax and semantics and the relationship of these components to typical and atypical reading development and reading instruction, cognitive academic language development, oral and written language proficiency (including second language development), acquisition of reading skills, and the variations related to cultural and linguistic diversity to provide effective instruction in reading and writing.

*f. Oral communication instruction.* This requirement includes the following competencies:

(1) The practitioner has knowledge of the unique needs and backgrounds of students with language differences and delays.

(2) The practitioner uses effective strategies for facilitating the learning of language for academic purposes by all learners.

*g. Written communication instruction.* This requirement includes the following competency: The practitioner uses knowledge of reading-writing-speaking connections; the writing process to include structures of language and grammar; the stages of spelling development; the different types of writing, such as narrative, expressive, persuasive, informational, and descriptive; and the connections between oral and written language development to effectively teach writing as communication.

*h. Children's fiction and nonfiction (K-8 only) or adolescent or young adult fiction and nonfiction (5-12 only).* This requirement includes the following competency: The practitioner uses knowledge of children's literature (K-8) or adolescent or young adult literature (5-12) for:

(1) Modeling the reading and writing of varied genres, including fiction and nonfiction; technology- and media-based information; and nonprint materials;

(2) Motivating through the use of texts at multiple levels, representing broad interests, and reflecting varied cultures, linguistic backgrounds, and perspectives; and

(3) Matching text complexities to the proficiencies and needs of readers.

*i. Practicum.* This requirement includes the following competencies:

(1) The practitioner works with appropriately licensed professionals who observe, evaluate, and provide feedback on the practitioner's knowledge, dispositions, and performance of the teaching of reading and writing.

(2) The practitioner effectively uses reading and writing strategies, materials, and assessments based upon appropriate reading and writing research and works with colleagues and families in the support of children's reading and writing development.

**13.28(16) Reading specialist.** K-12. The applicant must have met the requirements for the standard license and a K-8 or 5-12 reading endorsement and must present evidence of at least three years of experience which included the teaching of reading as a significant part of the responsibility.

*a. Authorization.* The holder of this endorsement is authorized to serve as a reading specialist in kindergarten and grades one through twelve.

*b. Program requirements.* Degree—master's.

*c. Content.* Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements. This sequence is to be at least 24 semester hours to include the following:

(1) Foundations of reading. The reading specialist will understand the historical, theoretical, and evidence-based foundations of reading and writing processes and instruction and will be able to interpret these findings to model exemplary instructional methods for students with typical and atypical literacy development and effectively develop and lead professional development.

(2) Curriculum and instruction. The reading specialist will use instructional approaches, materials, and an integrated, comprehensive, balanced curriculum to support student learning in reading and writing including the following:

1. Work collaboratively with teachers to develop a literacy curriculum that has vertical and horizontal alignment K-12 and that uses instructional approaches supported by literature and research for the following areas: print, phonemic awareness, phonics, fluency, comprehension, vocabulary, writing, critical thinking, and motivation.

2. Support classroom teachers to implement and adapt in-depth instructional approaches, including but not limited to approaches to improve decoding, comprehension, and information retention, to meet the language-proficiency needs of English language learners and the needs of students with reading difficulties or reading disabilities, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties within or outside the regular classroom.

3. Demonstrate a knowledge of a wide variety of quality traditional print, digital, and online resources and support classroom teachers in building and using a quality, accessible classroom library and materials collection that meets the specific needs and abilities of all learners.

4. Provide support for curriculum and instruction through modeling, coteaching, observing, planning, reviewing literacy data, and providing resources.

(3) Assessment, diagnosis, and evaluation. The reading specialist will use a variety of assessment tools and practices to plan and evaluate effective reading and writing instruction including the following:

1. Demonstrate an understanding of the literature and research related to assessments and their purposes, including the strengths and limitations of assessments, and assessment tools for screening, diagnosis, progress monitoring, and measuring outcomes; demonstrate an understanding of the signs and symptoms of reading difficulties including but not limited to dyslexia; and also demonstrate an understanding of district and state assessments, proficiency standards and student benchmarks.

2. Select, administer, and interpret assessments for specific purposes, including collaboration with teachers in the analysis of data, and leading schoolwide or districtwide scale analyses to select assessment tools that provide a systemic framework for assessing reading, writing, and language growth of all students, including those with reading difficulties and reading disabilities including but not limited to students with dyslexia and English language learners.

3. Use assessment information to plan and evaluate instruction, including multiple data sources for analysis and instructional planning, for examining the effectiveness of specific intervention practices and students' responses to interventions including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties, and to plan professional development initiatives.

4. Communicate assessment results and implications to a variety of audiences.

(4) Administration and supervision of reading programs. The reading specialist will:

1. Demonstrate foundational knowledge of adult learning theories and related research about organizational change, professional development, and school culture.

2. Demonstrate the practical application of literacy leadership including planning, developing, supervising, and evaluating literacy programs at all levels.

3. Demonstrate knowledge of supervising an overall reading program, including but not limited to staffing; budgetary practices; planning, preparing, and selecting materials; subsystems; special provisions; and evaluating teacher performance.

4. Participate in, design, facilitate, lead, and evaluate effective and differentiated professional development programs to effectively implement literacy instruction.

5. Demonstrate an understanding of local, state, and national policies that affect reading and writing instruction.

6. Promote effective communication and collaboration among stakeholders, including parents and guardians, teachers, administrators, policymakers, and community members, and advocate for change when necessary to promote effective literacy instruction.

(5) Educational research, measurement and evaluation. The reading specialist will effectively utilize existing research and learn to conduct new research to continuously improve the design and implementation of a comprehensive reading system.

(6) Psychology of language and reading. The reading specialist will understand the highly complex processes by which children learn to speak, read, and write, including language acquisition, linguistics including phonology and phonological awareness, sound-symbol association, syllable types, morphology, syntax and semantics and the relationship of these components to typical and atypical reading development and reading instruction, ranges of individual differences, reading difficulties and reading disabilities, including but not limited to dyslexia, and the importance of the role of diversity in learning to read and write.

(7) Practicum in reading leadership. The reading specialist will participate in elementary and secondary practicum experiences with licensed teachers who are serving in leadership roles in the area of reading.

**13.28(17) Science.**

*a. Science—basic. K-8.*

(1) Required coursework. Completion of at least 24 semester hours in science to include 12 hours in physical sciences, 6 hours in biology, and 6 hours in earth/space sciences.

(2) Pedagogy competencies.

1. Understand the nature of scientific inquiry, its central role in science, and how to use the skills and processes of scientific inquiry.

2. Understand the fundamental facts and concepts in major science disciplines.

3. Be able to make conceptual connections within and across science disciplines, as well as to mathematics, technology, and other school subjects.

4. Be able to use scientific understanding when dealing with personal and societal issues.

*b. Biological science. 5-12.* Completion of 24 semester hours in biological science or 30 semester hours in the broad area of science to include 15 semester hours in biological science.

*c. Chemistry. 5-12.* Completion of 24 semester hours in chemistry or 30 semester hours in the broad area of science to include 15 semester hours in chemistry.

*d. Earth science. 5-12.* Completion of 24 semester hours in earth science or 30 semester hours in the broad area of science to include 15 semester hours in earth science.

*e. Basic science. 5-12.* Completion of 24 semester hours of credit in science to include the following:

(1) Six semester hours of credit in earth and space science to include the following essential concepts and skills:

1. Understand and apply knowledge of energy in the earth system.
2. Understand and apply knowledge of geochemical cycles.

(2) Six semester hours of credit in life science/biological science to include the following essential concepts and skills:

1. Understand and apply knowledge of the cell.
2. Understand and apply knowledge of the molecular basis of heredity.
3. Understand and apply knowledge of the interdependence of organisms.
4. Understand and apply knowledge of matter, energy, and organization in living systems.
5. Understand and apply knowledge of the behavior of organisms.

(3) Six semester hours of credit in physics/physical science to include the following essential concepts and skills:

1. Understand and apply knowledge of the structure of atoms.
2. Understand and apply knowledge of the structure and properties of matter.
3. Understand and apply knowledge of motions and forces.
4. Understand and apply knowledge of interactions of energy and matter.

(4) Six semester hours of credit in chemistry to include the following essential concepts and skills:

1. Understand and apply knowledge of chemical reactions.
2. Be able to design and conduct scientific investigations.

*f. Physical science.* Rescinded IAB 11/14/12, effective 12/19/12.

*g. Physics.*

(1) 5-12. Completion of 24 semester hours in physics or 30 semester hours in the broad area of science to include 15 semester hours in physics.

(2) For holders of the mathematics 5-12 endorsement, completion of:

1. 12 credits of physics to include coursework in mechanics, electricity, and magnetism; and
2. A methods class that includes inquiry-based instruction, resource management, and laboratory safety.

(3) For holders of the chemistry 5-12 endorsement, completion of 12 credits of physics to include coursework in mechanics, electricity, and magnetism.

*h. All science I.* Rescinded IAB 11/14/12, effective 12/19/12.

*i. All science. 5-12.*

(1) Completion of 36 semester hours of credit in science to include the following:

1. Nine semester hours of credit in earth and space science to include the following essential concepts and skills:

- Understand and apply knowledge of energy in the earth system.
- Understand and apply knowledge of geochemical cycles.
- Understand and apply knowledge of the origin and evolution of the earth system.
- Understand and apply knowledge of the origin and evolution of the universe.

2. Nine semester hours of credit in life science/biological science to include the following essential concepts and skills:

- Understand and apply knowledge of the cell.
- Understand and apply knowledge of the molecular basis of heredity.
- Understand and apply knowledge of the interdependence of organisms.
- Understand and apply knowledge of matter, energy, and organization in living systems.
- Understand and apply knowledge of the behavior of organisms.
- Understand and apply knowledge of biological evolution.

3. Nine semester hours of credit in physics/physical science to include the following essential concepts and skills:

- Understand and apply knowledge of the structure of atoms.

- Understand and apply knowledge of the structure and properties of matter.
  - Understand and apply knowledge of motions and forces.
  - Understand and apply knowledge of interactions of energy and matter.
  - Understand and apply knowledge of conservation of energy and increase in disorder.
4. Nine semester hours of credit in chemistry to include the following essential concepts and skills:
- Understand and apply knowledge of chemical reactions.
  - Be able to design and conduct scientific investigations.
- (2) Pedagogy competencies.
1. Understand the nature of scientific inquiry, its central role in science, and how to use the skills and processes of scientific inquiry.
  2. Understand the fundamental facts and concepts in major science disciplines.
  3. Be able to make conceptual connections within and across science disciplines, as well as to mathematics, technology, and other school subjects.
  4. Be able to use scientific understanding when dealing with personal and societal issues.
- 13.28(18) Social sciences.**
- a. *American government.* 5-12. Completion of 24 semester hours in American government or 30 semester hours in the broad area of social sciences to include 15 semester hours in American government.
  - b. *American history.* 5-12. Completion of 24 semester hours in American history or 30 semester hours in the broad area of social sciences to include 15 semester hours in American history.
  - c. *Anthropology.* 5-12. Completion of 24 semester hours in anthropology or 30 semester hours in the broad area of social sciences to include 15 semester hours in anthropology.
  - d. *Economics.* 5-12. Completion of 24 semester hours in economics or 30 semester hours in the broad area of social sciences to include 15 semester hours in economics, or 30 semester hours in the broad area of business to include 15 semester hours in economics.
  - e. *Geography.* 5-12. Completion of 24 semester hours in geography or 30 semester hours in the broad area of social sciences to include 15 semester hours in geography.
  - f. *History.* K-8. Completion of 24 semester hours in history to include at least 9 semester hours in American history and 9 semester hours in world history.
  - g. *Psychology.* 5-12. Completion of 24 semester hours in psychology or 30 semester hours in the broad area of social sciences to include 15 semester hours in psychology.
  - h. *Social studies.* K-8. Completion of 24 semester hours in social studies, to include coursework from at least three of these areas: history, sociology, economics, American government, psychology and geography.
  - i. *Sociology.* 5-12. Completion of 24 semester hours in sociology or 30 semester hours in the broad area of social sciences to include 15 semester hours in sociology.
  - j. *World history.* 5-12. Completion of 24 semester hours in world history or 30 semester hours in the broad area of social sciences to include 15 semester hours in world history.
  - k. *All social sciences.* 5-12. Completion of 51 semester hours in the social sciences to include 9 semester hours in each of American and world history, 9 semester hours in government, 6 semester hours in sociology, 6 semester hours in psychology other than educational psychology, 6 semester hours in geography, and 6 semester hours in economics.
  - l. *Social sciences—basic.* 5-12. Completion of 27 semester hours to include 9 semester hours in each of American history, world history, and American government. Holders of the 5-12 social sciences—basic endorsement may add the following endorsements with 6 semester hours per endorsement area: 5-12 economics, 5-12 geography, 5-12 psychology, or 5-12 sociology.
- 13.28(19) Speech communication/theatre.**
- a. K-8. Completion of 20 semester hours in speech communication/theatre to include coursework in speech communication, creative drama or theatre, and oral interpretation.
  - b. 5-12. Completion of 24 semester hours in speech communication/theatre to include coursework in speech communication, oral interpretation, creative drama or theatre, argumentation and debate, and mass media communication.
- 13.28(20) English as a second language (ESL).** K-12.

*a. Authorization.* The holder of this endorsement is authorized to teach English as a second language in kindergarten and grades one through twelve.

*b. Content.* Completion of 18 semester hours of coursework in English as a second language to include the following:

- (1) Knowledge of pedagogy to include the following:
  1. Methods and curriculum to include the following:
    - Bilingual and ESL methods.
    - Literacy in native and second language.
    - Methods for subject matter content.
    - Adaptation and modification of curriculum.
  2. Assessment to include language proficiency and academic content.
- (2) Knowledge of linguistics to include the following:
  1. Psycholinguistics and sociolinguistics.
  2. Language acquisition and proficiency to include the following:
    - Knowledge of first and second language proficiency.
    - Knowledge of first and second language acquisition.
    - Language to include structure and grammar of English.
- (3) Knowledge of cultural and linguistic diversity to include the following:
  1. History.
  2. Theory, models, and research.
  3. Policy and legislation.
- (4) Current issues with transient populations.

**13.28(21) Elementary school teacher librarian.**

*a. Authorization.* The holder of this endorsement is authorized to serve as a teacher librarian in prekindergarten through grade eight.

*b. Content.* Completion of 24 semester hours in school library coursework to include the following:

- (1) Literacy and reading. This requirement includes the following competencies:
  1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy in children.
  2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading among children, based on familiarity with selection tools and current trends in literature for children.
- (2) Information and knowledge. This requirement includes the following competencies:
  1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.
  2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.
  3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.
  4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.
  5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.
  6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.
  7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.
- (3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

- (4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the elementary level.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the elementary level.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the elementary level.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula at the elementary level.

**13.28(22) Secondary school teacher librarian.**

- a. *Authorization.* The holder of this endorsement is authorized to serve as a teacher librarian in grades five through twelve.

- b. *Content.* Completion of 24 semester hours in school library coursework to include the following:

- (1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy in young adults.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading among young adults, based on familiarity with selection tools and current trends in literature for young adults.

- (2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

- (3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the secondary level.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the secondary level.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the secondary level.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula at the secondary level.

**13.28(23) School teacher librarian.** PK-12.

a. *Authorization.* The holder of this endorsement is authorized to serve as a teacher librarian in prekindergarten through grade twelve. The applicant must be the holder of or eligible for the initial license.

b. *Program requirements.* Degree—master's.

c. *Content.* Completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements. This sequence is to be at least 30 semester hours in school library coursework, to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy for youth of all ages.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading, based on familiarity with selection tools and current trends in literature for youth of all ages.

3. Practitioners understand how to develop a collection of reading and informational materials in print and digital formats that supports the diverse developmental, cultural, social and linguistic needs of all learners and their communities.

4. Practitioners model and teach reading comprehension strategies to create meaning from text for youth of all ages.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

8. Practitioners understand the process of collecting, interpreting, and using data to develop new knowledge to improve the school library program.

9. Practitioners employ the methods of research in library and information science.

(3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users of all ages.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

5. Practitioners demonstrate knowledge of best practices related to planning, budgeting (including alternative funding), organizing, and evaluating human and information resources and facilities to ensure equitable access.

6. Practitioners understand strategic planning to ensure that the school library program addresses the needs of diverse communities.

7. Practitioners advocate for school library and information programs, resources, and services among stakeholders.

8. Practitioners promote initiatives and partnerships to further the mission and goals of the school library program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the elementary and secondary levels.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the elementary and secondary levels.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the elementary and secondary levels.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula.

**13.28(24) Talented and gifted teacher.**

*a. Authorization.* The holder of this endorsement is authorized to serve as a teacher or a coordinator of programs for the talented and gifted from the prekindergarten level through grade twelve. This authorization does not permit general classroom teaching at any level except that level or area for which the holder is eligible or holds the specific endorsement.

*b. Program requirements—content.* Completion of 12 undergraduate or graduate semester hours of coursework in the area of the talented and gifted to include the following:

(1) Psychology of the gifted.

1. Social needs.

2. Emotional needs.

(2) Programming for the gifted.

1. Prekindergarten-12 identification.

2. Differentiation strategies.

3. Collaborative teaching skills.

4. Program goals and performance measures.

5. Program evaluation.

(3) Practicum experience in gifted programs.

NOTE: Teachers in specific subject areas will not be required to hold this endorsement if they teach gifted students in their respective endorsement areas.

**13.28(25) American Sign Language endorsement.**

*a. Authorization.* The holder of this endorsement is authorized to teach American Sign Language in kindergarten and grades one through twelve.

*b. Content.* Completion of 18 semester hours of coursework in American Sign Language to include the following:

- (1) Second language acquisition.
- (2) Sociology of the deaf community.
- (3) Linguistic structure of American Sign Language.
- (4) Language teaching methodology specific to American Sign Language.
- (5) Teaching the culture of deaf people.
- (6) Assessment of students in an American Sign Language program.

**13.28(26) Elementary professional school counselor.**

*a. Authorization.* The holder of this endorsement is authorized to serve as a professional school counselor in kindergarten and grades one through eight.

*b. Program requirements.* Master's degree from an accredited institution of higher education.

*c. Content.* Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include the following:

- (1) Nature and needs of individuals at all developmental levels.
  1. Develop strategies for facilitating development through the transition from childhood to adolescence and from adolescence to young adulthood.
  2. Apply knowledge of learning and personality development to assist students in developing their full potential.
- (2) Social and cultural foundations.
  1. Demonstrate awareness of and sensitivity to the unique social, cultural, and economic circumstances of students and their racial/ethnic, gender, age, physical, and learning differences.
  2. Demonstrate sensitivity to the nature and the functioning of the student within the family, school and community contexts.
  3. Demonstrate the counseling and consultation skills needed to facilitate informed and appropriate action in response to the needs of students.
- (3) Fostering of relationships.
  1. Employ effective counseling and consultation skills with students, parents, colleagues, administrators, and others.
  2. Communicate effectively with parents, colleagues, students and administrators.
  3. Counsel students in the areas of personal, social, academic, and career development.
  4. Assist families in helping their children address the personal, social, and emotional concerns and problems that may impede educational progress.
  5. Implement developmentally appropriate counseling interventions with children and adolescents.
  6. Demonstrate the ability to negotiate and move individuals and groups toward consensus or conflict resolution or both.
  7. Refer students for specialized help when appropriate.
  8. Value the well-being of the students as paramount in the counseling relationship.
- (4) Group work.
  1. Implement developmentally appropriate interventions involving group dynamics, counseling theories, group counseling methods and skills, and other group work approaches.
  2. Apply knowledge of group counseling in implementing appropriate group processes for elementary, middle school, and secondary students.
- (5) Career development, education, and postsecondary planning.
  1. Assist students in the assessment of their individual strengths, weaknesses, and differences, including those that relate to academic achievement and future plans.
  2. Apply knowledge of career assessment and career choice programs.
  3. Implement occupational and educational placement, follow-up and evaluation.
  4. Develop a counseling network and provide resources for use by students in personalizing the exploration of postsecondary educational opportunities.
- (6) Assessment and evaluation.
  1. Demonstrate individual and group approaches to assessment and evaluation.
  2. Demonstrate an understanding of the proper administration and uses of standardized tests.

3. Apply knowledge of test administration, scoring, and measurement concerns.
  4. Apply evaluation procedures for monitoring student achievement.
  5. Apply assessment information in program design and program modifications to address students' needs.
  6. Apply knowledge of legal and ethical issues related to assessment and student records.
- (7) Professional orientation.
1. Apply knowledge of history, roles, organizational structures, ethics, standards, and credentialing.
  2. Maintain a high level of professional knowledge and skills.
  3. Apply knowledge of professional and ethical standards to the practice of school counseling.
  4. Articulate the professional school counselor role to school personnel, parents, community, and students.
- (8) School counseling skills.
1. Design, implement, and evaluate a comprehensive, developmental school counseling program.
  2. Implement and evaluate specific strategies designed to meet program goals and objectives.
  3. Consult and coordinate efforts with resource persons, specialists, businesses, and agencies outside the school to promote program objectives.
  4. Provide information appropriate to the particular educational transition and assist students in understanding the relationship that their curricular experiences and academic achievements will have on subsequent educational opportunities.
  5. Assist parents and families in order to provide a supportive environment in which students can become effective learners and achieve success in pursuit of appropriate educational goals.
  6. Provide training, orientation, and consultation assistance to faculty, administrators, staff, and school officials to assist them in responding to the social, emotional, and educational development of all students.
  7. Collaborate with teachers, administrators, and other educators in ensuring that appropriate educational experiences are provided that allow all students to achieve success.
  8. Assist in the process of identifying and addressing the needs of the exceptional student.
  9. Apply knowledge of legal and ethical issues related to child abuse and mandatory reporting.
  10. Advocate for the educational needs of students and work to ensure that these needs are addressed at every level of the school experience.
  11. Promote use of school counseling and educational and career planning activities and programs involving the total school community to provide a positive school climate.
- (9) Classroom management.
1. Apply effective classroom management strategies as demonstrated in delivery of classroom and large group school counseling curriculum.
  2. Consult with teachers and parents about effective classroom management and behavior management strategies.
- (10) Curriculum.
1. Write classroom lessons including objectives, learning activities, and discussion questions.
  2. Utilize various methods of evaluating what students have learned in classroom lessons.
  3. Demonstrate competency in conducting classroom and other large group activities, utilizing an effective lesson plan design, engaging students in the learning process, and employing age-appropriate classroom management strategies.
  4. Design a classroom unit of developmentally appropriate learning experiences.
  5. Demonstrate knowledge in writing standards and benchmarks for curriculum.
- (11) Learning theory.
1. Identify and consult with teachers about how to create a positive learning environment utilizing such factors as effective classroom management strategies, building a sense of community in the classroom, and cooperative learning experiences.

2. Identify and consult with teachers regarding teaching strategies designed to motivate students using small group learning activities, experiential learning activities, student mentoring programs, and shared decision-making opportunities.

3. Demonstrate knowledge of child and adolescent development and identify developmentally appropriate teaching and learning strategies.

(12) Teaching and counseling practicum. The candidate will complete a preservice supervised practicum of a minimum of 100 hours, and at least 40 of these hours must be direct service. Candidates will complete a supervised internship for a minimum of 600 hours, and at least 240 of these hours must be direct service. For candidates seeking both the K-8 and 5-12 professional school counselor endorsements, a minimum of 100 hours of the practicum or internship experiences listed above must be completed at each of the desired endorsement levels.

**13.28(27) Secondary professional school counselor.**

a. *Authorization.* The holder of this endorsement is authorized to serve as a professional school counselor in grades five through twelve.

b. *Program requirements.* Master's degree from an accredited institution of higher education.

c. *Content.* Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

(1) The competencies listed in subparagraphs 13.28(26) "c"(1) to (11).

(2) The teaching and counseling practicum. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 13.28(26) "c"(12).

**13.28(28) School nurse endorsement.** The school nurse endorsement does not authorize general classroom teaching, although it does authorize the holder to teach health at all grade levels. Alternatively, a nurse may obtain a statement of professional recognition (SPR) from the board of educational examiners, in accordance with the provisions set out in 282—Chapter 16, Statements of Professional Recognition (SPR).

a. *Authorization.* The holder of this endorsement is authorized to provide service as a school nurse at the prekindergarten and kindergarten levels and in grades one through twelve.

b. *Content.*

(1) Organization and administration of school nurse services including the appraisal of the health needs of children and youth.

(2) School-community relationships and resources/coordination of school and community resources to serve the health needs of children and youth.

(3) Knowledge and understanding of the health needs of exceptional children.

(4) Health education.

c. *Other.* Hold a license as a registered nurse issued by the Iowa board of nursing.

**13.28(29) Athletic coach.** K-12. An applicant for the coaching endorsement must hold a teacher's license with one of the teaching endorsements.

a. *Authorization.* The holder of this endorsement may serve as a head coach or an assistant coach in kindergarten and grades one through twelve.

b. *Program requirements.*

(1) One semester hour college or university course in the structure and function of the human body in relation to physical activity, and

(2) One semester hour college or university course in human growth and development of children and youth as related to physical activity, and

(3) Two semester hour college or university course in athletic conditioning, care and prevention of injuries and first aid as related to physical activity, and

(4) One semester hour college or university course in the theory of coaching interscholastic athletics, and

(5) Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union, and

(6) A current certificate of CPR training.

**13.28(30) Content specialist endorsement.** Rescinded IAB 12/16/20, effective 1/20/21.

**13.28(31) Engineering. 5-12.**

- a. Completion of 24 semester hours in engineering coursework.
- b. Methods and strategies of STEM instruction or methods of teaching science or mathematics.

**13.28(32) STEM.****a. K-8.**

(1) Authorization. The holder of this endorsement is authorized to teach science, mathematics, and integrated STEM courses in kindergarten through grade eight.

(2) Program requirements. Be the holder of the teacher—elementary classroom endorsement.

**(3) Content.**

1. Completion of a minimum of 12 semester hours of college-level science.

2. Completion of a minimum of 12 semester hours of college-level math (or the completion of Calculus I) to include coursework in computer programming.

3. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:

- Engineering and technological design courses for education majors;
- Technology or engineering content coursework.

4. Completion of a minimum of 6 semester hours of required coursework in STEM curriculum and methods to include the following essential concepts and skills:

- Comparing and contrasting the nature and goals of each of the STEM disciplines;
- Promoting learning through purposeful, authentic, real-world connections;
- Integration of content and context of each of the STEM disciplines;
- Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
- Curriculum and standards mapping;
- Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;

- Assessment of integrative learning approaches;
- Information literacy skills in STEM;
- Processes of science and scientific inquiry;
- Mathematical problem-solving models;
- Communicating to a variety of audiences;
- Classroom management in project-based classrooms;
- Instructional strategies for the inclusive classroom;
- Computational thinking;
- Mathematical and technological modeling.

5. Completion of a STEM field experience of a minimum of 30 contact hours that may be met through the following:

- Completing a STEM research experience;
- Participating in a STEM internship at a STEM business or informal education organization; or
- Leading a STEM extracurricular activity.

**b. 5-8.**

(1) Authorization. The holder of this endorsement is authorized to teach science, mathematics, and integrated STEM courses in grades five through eight.

(2) Program requirements. Be the holder of a 5-12 science, mathematics, or industrial technology endorsement or 5-8 middle school mathematics or science endorsement.

**(3) Content.**

1. Completion of a minimum of 12 semester hours of college-level science.

2. Completion of a minimum of 12 semester hours of college-level math (or the completion of Calculus I) to include coursework in computer programming.

3. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:

- Engineering and technological design courses for education majors;
- Technology or engineering content coursework.

4. Completion of a minimum of 6 semester hours of required coursework in STEM curriculum and methods to include the following essential concepts and skills:

- Comparing and contrasting the nature and goals of each of the STEM disciplines;
- Promoting learning through purposeful, authentic, real-world connections;
- Integration of content and context of each of the STEM disciplines;
- Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);

- Curriculum and standards mapping;
- Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;

- Assessment of integrative learning approaches;
- Information literacy skills in STEM;
- Processes of science and scientific inquiry;
- Mathematical problem-solving models;
- Communicating to a variety of audiences;
- Classroom management in project-based classrooms;
- Instructional strategies for the inclusive classroom;
- Computational thinking;
- Mathematical and technological modeling.

5. Completion of a STEM field experience of a minimum of 30 contact hours that may be met through the following:

- Completing a STEM research experience;
- Participating in a STEM internship at a STEM business or informal education organization; or
- Leading a STEM extracurricular activity.

c. *Specialist K-12.*

(1) Authorization. The holder of this endorsement is authorized to serve as a STEM specialist in kindergarten and grades one through twelve.

(2) Program requirements.

1. The applicant must have met the requirements for a standard Iowa teaching license and a teaching endorsement in mathematics, science, engineering, industrial technology, or agriculture.

2. The applicant must hold a master's degree from a regionally accredited institution. The master's degree must be in math, science, engineering or technology or another area with at least 12 hours of college-level science and at least 12 hours of college-level math (or completion of Calculus I) to include coursework in computer programming.

(3) Content.

1. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:

- Engineering and technological design courses for education majors;
- Technology or engineering content coursework.

2. Completion of 9 semester hours in professional development to include the following essential concepts and skills:

- STEM curriculum and methods:
  - Comparing and contrasting the nature and goals of each of the STEM disciplines;
  - Promoting learning through purposeful, authentic, real-world connections;
  - Integration of content and context of each of the STEM disciplines;

- Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
  - Curriculum/standards mapping;
  - Assessment of integrative learning approaches;
  - Information literacy skills in STEM;
  - Processes of science/scientific inquiry;
  - Mathematical problem-solving models;
  - Classroom management in project-based classrooms;
  - Instructional strategies for the inclusive classroom;
  - Computational thinking;
  - Mathematical and technological modeling.
  - STEM experiential learning:
    - Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;
    - STEM research experiences;
    - STEM internship at a STEM business or informal education organization;
    - STEM extracurricular activity;
    - Communicating to a variety of audiences.
  - Leadership in STEM:
    - STEM curriculum development and assessment;
    - Curriculum mapping;
    - Assessment of student engagement;
    - STEM across the curriculum;
    - Research on best practices in STEM;
    - STEM curriculum accessibility for all students.
3. Completion of an internship/externship professional experience or prior professional experience in STEM for a minimum of 90 contact hours.

**13.28(33) Multioccupations.**

a. Completion of any 5-12 endorsement and, in addition thereto, coursework in foundations of career and technical education and coordination of cooperative programs, and work experience which meets one of the following:

- (1) Four thousand hours of career and technical experience in two or more careers; or
- (2) One thousand hours of work experience or externships in two or more careers and two or more years of teaching experience at the PK-12 level.

b. The multioccupations endorsement also authorizes the holder to supervise students in cooperative programs, work-based learning programs, and similar programs in which the student is placed in school-sponsored, on-the-job situations.

**13.28(34) CTE information technology. 5-12.**

a. *Authorization.* The holder of this endorsement is authorized to teach career and technical education (CTE) information technology, CTE computer science, and CTE computer programming courses.

b. *Program requirements.* Applicants must hold a valid Iowa teaching license with at least one other teaching endorsement.

c. *Content.* A minimum of 12 semester hours of computer science to include coursework in the following:

- (1) Data representation and abstraction to include primitive data types, static and dynamic data structures, and data types and stores.
- (2) Designing, developing, testing and refining algorithms to include proficiency in two or more programming paradigms.
- (3) Systems and networks to include operating systems, networks, mobile devices, and machine-level data representation.

*d. Methods course.* A content area methods course is required pursuant to 13.29(1). The course should include the following effective teaching and learning strategies for information technology:

(1) Curriculum development including recognizing and defining real-world computational problems; computing concepts and constructs; developing and using abstractions; creating, testing, and refining computational artifacts; and problem-solving strategies in computer science.

(2) Project-based methodologies that support active and authentic learning, fostering an inclusive computing culture, collaborative groupings, and opportunities for creative and innovative thinking.

(3) Communication about computing including multiple forms of media.

(4) Digital citizenship including the social, legal, ethical, safe and effective use of computer hardware, software, peripherals, and networks.

*e. CTE methods.*

(1) A minimum of six semester hours of career and technical curriculum and methods to include:

1. Foundations of career and technical education.

2. Methods of career and technical education.

3. Evaluation and assessment of career and technical programs.

(2) The CTE methods coursework is not required if the educator holds another career and technical endorsement.

*f. Waiver of coursework requirements.* During the first year of implementation, the coursework requirements may be waived if the practitioner demonstrates relevant content knowledge mastery and successful teaching experience in this endorsement area through criteria established by the board of educational examiners.

**13.28(35) Computer science.** K-8 and 5-12.

*a. Authorization.* The holder of this endorsement is authorized to teach selected computer science and computer programming courses.

*b. Program requirements.* Applicants must hold a valid Iowa teaching license with at least one additional teaching endorsement.

*c. Content.* A minimum of 12 semester hours of computer science to include coursework in the following:

(1) Data representation and abstraction to include primitive data types, static and dynamic data structures, and data types and stores.

(2) Designing, developing, testing and refining algorithms to include proficiency in two or more programming paradigms.

(3) Systems and networks to include operating systems, networks, mobile devices, and machine-level data representation.

*d. Methods course.* A content area methods course is required pursuant to 13.29(1). The course should include the following effective teaching and learning strategies for information technology:

(1) Curriculum development including recognizing and defining real-world computational problems; computing concepts and constructs; developing and using abstractions; creating, testing, and refining computational artifacts; and problem-solving strategies in computer science.

(2) Project-based methodologies that support active and authentic learning, fostering an inclusive computing culture, collaborative groupings, and opportunities for creative and innovative thinking.

(3) Communication about computing including multiple forms of media.

(4) Digital citizenship including the social, legal, ethical, safe and effective use of computer hardware, software, peripherals, and networks.

*e. Computer science specialist.* If the requirements in 13.28(35)“c” and “d” are met and the applicant achieves a minimum of 24 semester hours of computer science content, a computer science specialist endorsement will be granted and the additional teaching endorsement set forth in 13.28(35)“b” will not be required.

*f. Waiver of coursework requirements.* During the first year of implementation, the coursework requirements may be waived if the practitioner demonstrates relevant content knowledge mastery and successful teaching experience in this endorsement area through criteria established by the board of educational examiners.

**13.28(36) *Dyslexia specialist.*** K-12. The applicant must have met the requirements for the standard license and have completed at least three years of post-baccalaureate teaching experience in a K-12 setting. Applicants who have achieved dyslexia certification in another state prior to March 17, 2021, may apply for a certification review.

*a. Authorization.* The holder of this endorsement is authorized to serve as a dyslexia specialist in kindergarten and grades 1 through 12.

*b. Content.* Completion of 18 semester hours in dyslexia strategies to include the following:

(1) Knowledge of dyslexia. The dyslexia specialist will have knowledge of dyslexia and:

1. Understand the tenets of the International Dyslexia Association's definition of dyslexia, including the neurobiological nature and cognitive-linguistic correlates.

2. Identify distinguishing characteristics of dyslexia and commonly co-occurring disorders, including dysgraphia, dyscalculia, attention deficit hyperactivity disorder, expressive language disorders, receptive language disorders, and others.

3. Recognize that dyslexia may present differently along a continuum of severity and impact depending upon age, grade, and compensatory factors.

4. Understand federal and state laws that pertain to dyslexia, including use of the word "dyslexia" within school settings and documentation.

5. Understand common misconceptions regarding characteristics of and interventions for dyslexia.

(2) Psychology of language and reading. The dyslexia specialist will understand the highly complex processes by which children learn to speak, read, and write, including language acquisition, linguistics, and the structure of written language, including phonological processing, phonics, orthography, morphology, syntax, and semantics, as well as the relationship of these components to typical and atypical reading and writing development and instruction for students with dyslexia.

(3) Curriculum and instruction. The dyslexia specialist will use appropriate instructional approaches and materials as well as integrated, comprehensive, explicit, and systematic literacy instruction to support student learning in reading and writing, including the following:

1. Instruction utilizing multisensory and multimodal strategies (visual, auditory, kinesthetic, and tactile), systematic and cumulative instruction, direct instruction, diagnostic and prescriptive teaching, as well as synthetic and analytic instruction.

2. Instructional approaches supported by the science of reading for the following areas: phonological processing, phonics, fluency, comprehension, vocabulary, spelling, and writing.

3. Creation of a dyslexia-friendly learning environment (within or outside the regular classroom) utilizing evidence-based accommodations and modifications to meet the needs of students with dyslexia, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia.

4. Use of data to determine effectiveness of the instruction and curriculum along with student responsiveness to it.

(4) Assessment, diagnosis, and evaluation. The dyslexia specialist will be confident using a variety of formal assessment tools and practices to evaluate students' reading and writing abilities in a variety of domains. The dyslexia specialist will:

1. Demonstrate an understanding of the literature and research related to assessments and their purposes (including the strengths and limitations of assessments) and assessment tools for screening, diagnosis, progress monitoring, and measuring outcomes.

2. Demonstrate an understanding of the signs and symptoms of reading difficulties, including but not limited to dyslexia; and also demonstrate an understanding of norms and student benchmarks.

3. Select, administer, and interpret assessments for specific purposes, including screening students at risk for dyslexia and identifying students who display a profile of dyslexia, and:

- Understand the features of standardized norm-referenced assessments.

- Understand the importance of selecting reliable and valid assessments to evaluate typical and atypical reading development.

- Interpret various scores derived from standardized norm-referenced and criterion-referenced assessments.

4. Use assessment information to plan and evaluate instruction, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties. This will include the use of multiple data sources for analysis, instructional planning, examining the effectiveness of specific intervention practices, and examining students' responses to interventions.

5. Communicate assessment results and implications to a variety of audiences, including staff, parents, and students.

6. Understand appropriate IEP goals and Section 504 plans for students who display characteristics of dyslexia.

(5) Practicum in dyslexia. The dyslexia specialist will participate in elementary and secondary practicum experiences with instructors who have experience with and are currently serving students who display characteristics of dyslexia. The cooperating teacher must be approved by the Iowa reading research center. The practicum must include:

1. Supervised administration of norm-referenced literacy assessments.

2. Practice composing a report of literacy assessment results that will include interpretation of the results and instructional recommendations.

3. Supervised delivery of systematic, explicit, and multisensory intervention for students with characteristics of dyslexia.

4. Practice composing a report of students' response to intervention.  
 [ARC 7986B, IAB 7/29/09, effective 9/2/09; ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 8403B, IAB 12/16/09, effective 1/20/10; ARC 9070B, IAB 9/8/10, effective 10/13/10; ARC 9071B, IAB 9/8/10, effective 10/13/10; ARC 9210B, IAB 11/3/10, effective 12/8/10; ARC 9211B, IAB 11/3/10, effective 12/8/10; ARC 9212B, IAB 11/3/10, effective 12/8/10; ARC 9838B, IAB 11/2/11, effective 12/7/11; ARC 9839B, IAB 11/2/11, effective 12/7/11; ARC 0448C, IAB 11/14/12, effective 12/19/12; ARC 0449C, IAB 11/14/12, effective 12/19/12; ARC 0866C, IAB 7/24/13, effective 8/28/13; ARC 0875C, IAB 7/24/13, effective 8/28/13; ARC 0986C, IAB 9/4/13, effective 10/9/13; ARC 1085C, IAB 10/16/13, effective 11/20/13; ARC 1171C, IAB 11/13/13, effective 12/18/13; ARC 1328C, IAB 2/19/14, effective 3/26/14; ARC 1327C, IAB 2/19/14, effective 3/26/14; ARC 2015C, IAB 6/10/15, effective 7/15/15; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2397C, IAB 2/17/16, effective 3/23/16; ARC 2586C, IAB 6/22/16, effective 7/27/16; ARC 2793C, IAB 11/9/16, effective 12/14/16; see Delay note at end of chapter; ARC 3197C, IAB 7/5/17, effective 8/9/17; ARC 3634C, IAB 2/14/18, effective 3/21/18; ARC 5322C, IAB 12/16/20, effective 1/20/21; ARC 5416C, IAB 2/10/21, effective 3/17/21]

## **282—13.29(272) Adding, removing or reinstating a teaching endorsement.**

**13.29(1) Adding an endorsement.** After the issuance of a teaching license, an individual may add other endorsements to that license upon proper application, provided current requirements for that endorsement have been met. An updated license with expiration date unchanged from the original or renewed license will be prepared.

*a. Options.* To add an endorsement, the applicant must follow one of these options:

(1) Option 1. Receive the Iowa teacher education institution's recommendation that the current approved program requirements for the endorsement have been met.

(2) Option 2. Receive verification from the Iowa teacher education institution that the minimum state requirements for the endorsement have been met in lieu of the institution's approved program.

(3) Option 3. Apply for a review of the transcripts by the board of educational examiners' staff to determine if all Iowa requirements have been met. The applicant must submit documentation that all of the Iowa requirements have been met by filing transcripts and supporting documentation for review. The fee for the transcript evaluation is in 282—Chapter 12. This fee shall be in addition to the fee for adding the endorsement.

*b. Additional requirements for adding an endorsement.*

(1) In addition to meeting the requirements for Iowa licensure, applicants for endorsements shall have completed a methods class appropriate for teaching the general subject area and grade levels of the endorsement added.

(2) Practitioners who are adding a K-8 endorsement and have not student taught at the elementary level shall complete a teaching practicum in an elementary setting. Applicants seeking the early childhood or elementary endorsements set forth in rule 282—13.26(272) must complete the required field experience and teaching practicum specific to the endorsement desired.

(3) Practitioners who are adding a 5-12 endorsement and have not student taught at the secondary level shall complete a teaching practicum in a high school setting.

(4) Practitioners holding the K-8 endorsement in the content area of the 5-12 endorsement being added may satisfy the requirement for the secondary methods class and the teaching practicum by completing all required coursework and presenting verification of competence. This verification of competence shall be signed by a licensed evaluator who has observed and formally evaluated the performance of the applicant at the secondary level. This verification of competence may be submitted at any time during the term of the Class B license. The practitioner must obtain a Class B license while practicing with the 5-12 endorsement.

(5) Applicants seeking a board of educational examiners transcript review must have achieved a C- grade or higher in the courses that will be considered for an endorsement.

**13.29(2) Removal of an endorsement; reinstatement of removed endorsement.**

*a. Removal of an endorsement.* A practitioner may remove an endorsement from the practitioner's license as follows:

(1) To remove an endorsement, the practitioner shall meet the following conditions:

1. A practitioner who holds a standard or master educator license is eligible to request removal of an endorsement from the license if the practitioner has not taught in the subject or assignment area of the endorsement in the five years prior to the request for removal of the endorsement, and

2. The practitioner must submit a notarized written application form furnished by the board of educational examiners to remove an endorsement at the time of licensure renewal (licensure renewal is limited to one calendar year prior to the expiration date of the current license), and

3. The application must be signed by the superintendent or designee in the district in which the practitioner is under contract. The superintendent's signature shall serve as notification and acknowledgment of the practitioner's intent to remove an endorsement from the practitioner's license. The absence of the superintendent's or designee's signature does not impede the removal process.

(2) The endorsement shall be removed from the license at the time of application.

(3) If a practitioner is not employed and submits an application, the provisions of 13.29(2) "a"(1)"3" shall not be required.

(4) If a practitioner submits an application that does not meet the criteria listed in 13.29(2) "a"(1)"1" to "3," the application will be rendered void and the practitioner will forfeit the processing fee.

(5) The executive director has the authority to approve or deny the request for removal. Any denial is subject to the appeal process set forth in rule 282—11.35(272).

*b. Reinstatement of a removed endorsement.*

(1) If the practitioner wants to add the removed endorsement at a future date, all coursework for the endorsement must be completed within the five years preceding the application to add the endorsement.

(2) The practitioner must meet the current endorsement requirements when making application.

[ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 2016C, IAB 6/10/15, effective 7/15/15; ARC 2584C, IAB 6/22/16, effective 7/27/16]

**282—13.30(272) Licenses—issue and expiration dates, corrections, duplicates, and fraud.**

**13.30(1) Issue and expiration dates on original license.** A license is valid only from and after the date of issuance. Licenses, authorizations, certificates, and statements of professional recognition will expire on the last day of the practitioner's birth month after the term of the license unless otherwise specified. If the expiration date is changed by rule, the change may be retroactive.

**13.30(2) Correcting licenses.** If a licensee notifies board staff of a typographical or clerical error on the license within 30 days of the date of the board's mailing of a license, a corrected license shall be issued without charge to the licensee. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of a license, a corrected license shall be issued upon receipt of the fee for issuance of a duplicate license. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of a license, errors in the type of license issued, and the omission or misidentification of the endorsements for which application was made. A licensee

requesting the addition of an endorsement not included on the initial application must submit a new application and the appropriate application fee.

**13.30(3) Duplicate licenses.** Upon application and payment of the fee set out in 282—Chapter 12, a duplicate license shall be issued.

**13.30(4) Fraud in procurement or renewal of licenses.** Fraud in procurement or renewal of a license or falsifying records for licensure purposes will constitute grounds for filing a complaint with the board of educational examiners.

[ARC 3979C, IAB 8/29/18, effective 10/3/18]

These rules are intended to implement Iowa Code chapter 272 and 2014 Iowa Acts, chapter 1116, division VI.

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<sup>1</sup> December 14, 2016, effective date of 13.28(29)“b”(6) [ARC 2793C, Item 1] delayed until the adjournment of the 2017 General Assembly by the Administrative Rules Review Committee at its meeting held December 13, 2016.

<sup>2</sup> January 6, 2021, effective date of 13.6 [ARC 5303C, Item 1] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held December 8, 2020.

CHAPTER 22  
AUTHORIZATIONS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 19]

**282—22.1(272) Coaching authorization.** A coaching authorization allows an individual to coach any sport in a middle school, junior high school, or high school.

**22.1(1) Application process.** Any person interested in the coaching authorization shall submit records of credit to the board of educational examiners for an evaluation in terms of the required courses or contact hours. Application materials are available from the office of the board of educational examiners, online at [www.boee.iowa.gov](http://www.boee.iowa.gov), or from institutions or agencies offering approved courses or contact hours.

**22.1(2) Requirements.** Applicants for the coaching authorization shall have completed the following requirements:

*a. Credit hours.* Applicants must complete credit hours in the following areas:

(1) Successful completion of 1 semester credit hour or 10 contact hours in a course relating to knowledge and understanding of the structure and function of the human body in relation to physical activity.

(2) Successful completion of 1 semester credit hour or 10 contact hours in a course relating to knowledge and understanding of human growth and development of children and youth in relation to physical activity.

(3) Successful completion of 2 semester credit hours or 20 contact hours in a course relating to knowledge and understanding of the prevention and care of athletic injuries and medical and safety problems relating to physical activity.

(4) Successful completion of 1 semester credit hour or 10 contact hours relating to knowledge and understanding of the techniques and theory of coaching interscholastic athletics.

(5) Beginning on or after July 1, 2000, each applicant for an initial coaching authorization shall have successfully completed 1 semester credit hour or 15 contact hours in a course relating to the theory of coaching which must include at least 5 contact hours relating to the knowledge and understanding of professional ethics and legal responsibilities of coaches.

(6) Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union.

(7) Successful completion of CPR training as verified by a current certificate.

*b. Minimum age or diploma.* Applicants must have attained a minimum of 18 years. Applicants must also:

(1) Possess a minimum of:

1. A high school diploma,

2. A graduate equivalent diploma, or

3. Home school completion verified by the executive director; or

(2) Be 20 years of age or older.

*c. Background check.* Applicants must complete the background check requirements set forth in rule 282—13.1(272).

*d. License without deficiencies.* Applicants who hold a coaching license, certificate, or authorization from at least one other issuing jurisdiction in another state will not be subject to additional coursework if the following requirements have been met:

(1) Verification of Iowa residency in the state of Iowa, or, for military spouses, verification of a permanent change of military installation.

(2) Valid or expired equivalent license in good standing from another state without pending disciplinary action, valid for a minimum of one year, exclusive of a temporary, emergency or substitute license or certificate.

**22.1(3) Validity.** The coaching authorization shall be valid for five years.

**22.1(4) Renewal.** The authorization may be renewed upon application and verification of successful completion of:

a. Renewal activities. Applicants for renewal of a coaching authorization must:

(1) Successfully complete five planned renewal activities/courses related to athletic coaching approved in accordance with guidelines approved by the board of educational examiners. Additionally, each applicant for the renewal of a coaching authorization shall have completed one renewal activity/course relating to the knowledge and understanding of professional ethics and legal responsibilities of coaches.

(2) Annually complete the concussion training approved by the Iowa High School Athletic Association or the Iowa Girls High School Athletic Union. Completion of the concussion training may be waived if the applicant is not serving as a coach. Attendance at the annual concussion training may be used for a maximum of one planned activity/course required in 22.1(4)“a”(1).

(3) Complete child and dependent adult abuse trainings. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse trainings pursuant to 282—subrule 20.3(4). These trainings combined may be used for a total of one planned activity/course required in 22.1(4)“a”(1).

(4) Provide a current certificate of CPR training.

b. A one-year extension of the applicant’s coaching authorization may be issued if all requirements for the renewal of the coaching authorization have not been met. The applicant must complete the concussion training approved by the Iowa High School Athletic Association or the Iowa Girls High School Athletic Union before serving as a coach. The one-year extension is not renewable. The fee for this extension is found in 282—Chapter 12.

**22.1(5) Revocation and suspension.** Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the coaching authorization. An ethics complaint may be filed if a practitioner begins coaching a sport without current concussion training.

**22.1(6) Approval of courses.** Each institution of higher education, private college or university, merged area school or area education agency wishing to offer the semester credit or contact hours for the coaching authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

**22.1(7) Transitional coaching authorization.**

a. *Application process.* Any person interested in the transitional coaching authorization shall submit a complete application verifying the requirements listed below. Application materials are available from the board of educational examiners online at [www.boee.iowa.gov](http://www.boee.iowa.gov).

b. *Requirements.* Applicants for the transitional coaching authorization shall have completed each of the following requirements:

(1) Verification that the applicant has not completed the coursework required for a coaching authorization.

(2) Verification of an offer of a coaching position by a school or a consortium of schools that will additionally verify that:

1. No fully authorized coaching candidates were found after a diligent search,

2. The transitional coach will be supervised by a licensed athletic director, administrator, or other practitioner serving in a supervisory role during the first two weeks of employment, and

3. The supervisor will evaluate the performance of the transitional coach using an evaluation form available on the school’s website.

(3) Successful completion of an approved shortened course of training related to the code of professional rights and responsibilities, practices, and ethics specifically developed for transitional coaches.

(4) Successful completion of the child and dependent adult abuse trainings pursuant to 282—subrule 20.3(4).

(5) Successful completion of a nationally recognized concussion in youth sports training course.

(6) Verification that the applicant has attained a minimum age of 21 years.

(7) Verification of completion of the background check requirements set forth in rule 282—13.1(272).

*c. Validity.* The transitional coaching authorization shall be valid for no more than one year and shall be valid only in the school or consortium of schools making the offer of the coaching position.

*d. Renewal.* The transitional coaching authorization is nonrenewable.

*e. Revocation and suspension.* Criteria of professional practice and rules of the board of educational examiners shall apply to holders of a transitional coaching authorization. An ethics complaint may be filed if a practitioner begins coaching a sport without current concussion training. [ARC 0865C, IAB 7/24/13, effective 8/28/13; ARC 0866C, IAB 7/24/13, effective 8/28/13; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 2588C, IAB 6/22/16, effective 7/27/16; ARC 2793C, IAB 11/9/16, effective 12/14/16; see Delay note at end of chapter; ARC 4634C, IAB 8/28/19, effective 10/2/19; ARC 5321C, IAB 12/16/20, effective 1/20/21]

**282—22.2(272) Substitute authorization.** A substitute authorization allows an individual to substitute in grades PK-12 for no more than ten consecutive days in one job assignment for a regularly assigned teacher who is absent, except in the driver's education classroom. A school district administrator may file a written request with the board for an extension of the ten-day limit in one job assignment on the basis of documented need and benefit to the instructional program. The executive director or appointee will review the request and provide a written decision either approving or denying the request.

**22.2(1) Application process.** Any person interested in the substitute authorization shall submit records of credit to the board of educational examiners for an evaluation in terms of the required courses or contact hours. Application materials are available from the office of the board of educational examiners, online at [www.boee.iowa.gov](http://www.boee.iowa.gov) or from institutions or agencies offering approved courses or contact hours.

*a. Requirements.* Applicants for the substitute authorization shall meet the following requirements:

(1) Authorization program. Applicants must complete a board of educational examiners-approved substitute authorization program consisting of the following components and totaling a minimum of 15 clock hours:

1. Classroom management. This component includes an understanding of individual and group motivation and behavior to create a learning environment that encourages positive social interaction, active engagement in learning, and self-motivation.

2. Strategies for learning. This component includes understanding and using a variety of learning strategies to encourage students' development of critical thinking, problem solving, and performance skills.

3. Diversity. This component includes understanding how students differ in their approaches to learning and creating learning opportunities that are equitable and are adaptable to diverse learners.

4. Ethics. This component includes fostering relationships with parents, school colleagues, and organizations in the larger community to support students' learning and development and to be aware of the board's rules of professional practice and competent performance.

(2) Degree or certificate. Applicants must have achieved a minimum of an associate's degree or 60 semester hours of college coursework from a regionally accredited institution.

(3) Minimum age. Applicants must have attained a minimum age of 21 years.

(4) Background check. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

*b. Additional requirements.* An applicant under this subrule shall be granted a substitute authorization and will not be subject to the authorization program coursework if the following additional requirements have been met:

(1) Verification of Iowa residency or, for military spouses, verification of a permanent change of military installation.

(2) Valid or expired substitute authorization in good standing from another state without pending disciplinary action, valid for a minimum of one year, exclusive of a temporary, emergency license or certificate.

*c. Validity.* The substitute authorization shall be valid for five years.

*d. Renewal.* The authorization may be renewed upon application and verification of successful completion of:

(1) Renewal units. Applicants for renewal of the substitute authorization must provide verification of a minimum of two licensure renewal units or semester hours of renewal credits.

(2) Child and dependent adult abuse trainings. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse trainings pursuant to 282—subrule 20.3(4).

**22.2(2) Revocation and suspension.** Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the substitute authorization.

**22.2(3) Approval of courses.** Each institution of higher education, private college or university, merged area school or area education agency wishing to offer the semester credit or contact hours for the substitute authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 7745B, IAB 5/6/09, effective 6/10/09; ARC 0865C, IAB 7/24/13, effective 8/28/13; ARC 1087C, IAB 10/16/13, effective 11/20/13; ARC 1720C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 2528C, IAB 5/11/16, effective 6/15/16; ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 4634C, IAB 8/28/19, effective 10/2/19; ARC 4635C, IAB 8/28/19, effective 10/2/19; ARC 5303C, IAB 12/2/20, effective 1/6/21; see Delay note at end of chapter]

### **282—22.3(272) School business official authorization.**

**22.3(1) Application for authorization.** Effective July 1, 2012, a person who is interested in a school business official authorization will be required to apply for an authorization.

**22.3(2) Responsibilities.** A school business official authorization allows an individual to perform, supervise, and be responsible for the overall financial operation of a local school district.

**22.3(3) Application process.** Any person interested in the school business official authorization shall submit records of credit to the board of educational examiners for an evaluation in terms of the required courses or contact hours. Application materials are available from the office of the board of educational examiners, online at [www.boee.iowa.gov](http://www.boee.iowa.gov), or from institutions or agencies offering approved courses or contact hours.

**22.3(4) Specific requirements for an initial school business official authorization.** Applicants for an initial school business official authorization shall have completed the following requirements:

*a. Education.* Applicants must have a minimum of an associate's degree in business or accounting or 60 semester hours of coursework in business or accounting of which 9 semester hours must be in accounting.

If the applicant has not completed 9 semester hours in accounting but has 6 or more semester hours in accounting, the applicant may be issued a temporary school business official authorization valid for one year.

(1) A temporary initial school business official authorization may be issued if requested by the district. A district administrator may file a written request with the executive director for an exception to the minimum content requirements on the basis of documented need and benefit to the district. The executive director will review the request and provide a written decision either approving or denying the request.

(2) If the 9 semester hours of accounting are not completed within the time allowed, the applicant will not be eligible for the initial school business official authorization.

(3) If the applicant received a temporary school business official authorization, then the initial school business official authorization shall not exceed one year.

*b. Minimum age.* Applicants must have attained a minimum age of 18 years.

*c. Background check.* Applicants must complete the background check requirements set forth in rule 282—13.1(272).

**22.3(5) Specific requirements for a standard school business official authorization.**

*a.* A standard school business official authorization will be valid for three years and may be issued to an applicant who meets the requirements set forth in subrules 22.3(3) to 22.3(5).

*b. Requirements.*

(1) Applicants must complete 9 semester hours or the equivalent (1 semester hour is equivalent to 15 contact hours) in an approved program in the following areas/competencies:

1. Accounting (GAAP) concepts: fund accounting, account codes, Uniform Financial Accounting.
2. Accounting cycles: budgets, payroll/benefits, purchasing/inventory, cash, receipts, disbursements, financial reporting, investments.
3. Technology: management of accounting systems, proficiency in understanding and use of systems technology and related programs.
4. Regulatory: Uniform Administrative Procedures Manual, school policies and procedures, administrative procedures, public records law, records management, school law, employment law, construction and bidding law.
5. Personal skills: effective communication and interpersonal skills, ethical conduct, information management, ability to analyze and evaluate, ability to recognize and safeguard confidential information, and accurate and timely performance.

(2) Applicants shall demonstrate completion of or competency in the following:

1. A board of educational examiners ethics program.
2. A mentoring program as described in 281—Chapter 81.
3. The promotion of the value of the school business official's fiduciary responsibility to the taxpayer.

**22.3(6) Validity.**

*a.* The initial school business official authorization shall be valid for two years.

*b.* The standard school business official authorization shall be valid for three years.

**22.3(7) Renewal.** The authorization may be renewed upon application and verification of successful completion of:

*a.* Renewal activities.

(1) In addition to the child and dependent adult abuse mandatory reporter training listed below, the applicant for renewal must complete 4 semester hours of credit or the equivalent contact hours (1 semester hour is equivalent to 15 contact hours) within the three-year licensure period.

(2) Failure to complete requirements for renewal will require a petition for waiver from the board.

*b.* Child and dependent adult abuse mandatory reporter trainings. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse mandatory reporter trainings pursuant to 282—subrule 20.3(4).

**22.3(8) Revocation and suspension.** Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the school business official authorization.

**22.3(9) Approval of courses.** Each institution of higher education, private college or university, merged area school or area education agency and professional organization that wishes to offer the semester credit hours or contact hours for the school business official authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 9572B, IAB 6/29/11, effective 8/3/11; ARC 0869C, IAB 7/24/13, effective 8/28/13; ARC 1719C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 3196C, IAB 7/5/17, effective 8/9/17; ARC 4634C, IAB 8/28/19, effective 10/2/19]

## **282—22.4(272) Licenses—issue dates, corrections, duplicates, and fraud.**

**22.4(1) Issue date on original authorization.** An authorization is valid only from and after the date of issuance.

**22.4(2) Correcting authorization.** If an applicant notifies board staff of a typographical or clerical error on the authorization within 30 days of the date of the board's mailing of an authorization, a corrected authorization shall be issued without charge to the applicant. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of an authorization, a corrected authorization shall be issued upon receipt of the fee for issuance of a duplicate authorization. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of an authorization, or errors in the type of authorization issued.

**22.4(3) Duplicate authorization.** Upon application and payment of the fee set out in 282—Chapter 12, a duplicate authorization shall be issued.

**22.4(4) Fraud in procurement or renewal of authorization.** Fraud in procurement or renewal of an authorization or falsifying records for authorization purposes will constitute grounds for filing a complaint with the board of educational examiners.

[ARC 9572B, IAB 6/29/11, effective 8/3/11]

**282—22.5(272) Preliminary native language teaching authorization.**

**22.5(1) Authorization.** The preliminary native language teaching authorization is provided to noneducators entering the education profession to teach their native language as a foreign language in grades K-6 or grades 7-12.

**22.5(2) Application process.** Any person interested in the preliminary native language teaching authorization shall submit the application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at [www.boee.iowa.gov](http://www.boee.iowa.gov).

**22.5(3) Requirements.**

a. The applicant must have completed a baccalaureate degree.

b. Background check. The applicant must complete the background check requirements set forth in rule 282—13.1(272).

c. The applicant must obtain a recommendation from a school district administrator verifying that the school district wishes to hire the applicant. Before the applicant is hired, the school district administrator must verify that a diligent search was completed to hire a fully licensed teacher for the position.

d. During the term of the authorization, the applicant must complete board-approved training in the following:

(1) Methods and techniques of teaching. Develop skills to use a variety of learning strategies that encourage students' development of critical thinking, problem solving, and performance skills. The methods course must include specific methods and techniques of teaching a foreign language and must be appropriate for the level of endorsement.

(2) Curriculum development. Develop an understanding of how students differ in their approaches to learning and create learning opportunities that are equitable and adaptable to diverse learners.

(3) Measurement and evaluation of programs and students. Develop skills to use a variety of authentic assessments to measure student progress.

(4) Classroom management. Develop an understanding of individual and group motivation and behavior which creates a learning environment that encourages positive social interactions, active engagement in learning, and self-motivation.

(5) Code of ethics. Develop an understanding of how to foster relationships with parents, school colleagues, and organizations in the larger community to support students' learning and development and become aware of the board's rules of professional practice and code of ethics.

(6) Diversity training for educators. Develop an understanding of and sensitivity to the values, beliefs, lifestyles and attitudes of individuals and the diverse groups found in a pluralistic society, including preparation that contributes to the education of individuals with disabilities and the gifted and talented.

e. The applicant must be assigned a mentor by the hiring school district. The mentor must have four years of teaching experience in a related subject area.

f. Assessment of native language. The applicant must provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education. The cut score may not be waived by the board.

**22.5(4) Validity.** This authorization is valid for three years. No conditional licenses may be issued to applicants holding the preliminary native language teaching authorization. No additional endorsement areas may be added.

**22.5(5) Renewal.** The authorization is nonrenewable.

**22.5(6) Conversion.** The preliminary native language teaching authorization may be converted to a native language teaching authorization. The applicant must provide official transcripts verifying the completion of the coursework required in 22.5(3)“d.”

**22.5(7) Revocation and suspension.** Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the preliminary native language teaching authorization. If a school district hires an applicant without a valid preliminary native language teaching authorization, a complaint may be filed against the teacher and the superintendent of the school district.

**22.5(8) Approval of courses.** Each institution of higher education, private college or university, community college or area education agency wishing to offer the training for the preliminary native language teaching authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 0562C, IAB 1/23/13, effective 2/27/13; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 3196C, IAB 7/5/17, effective 8/9/17]

## **282—22.6(272) Native language teaching authorization.**

**22.6(1) Authorization.** The native language teaching authorization allows an individual to teach the individual’s native language as a foreign language in grades K-8 or grades 5-12.

**22.6(2) Application process.** Any person interested in the native language teaching authorization shall submit an application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at [www.boee.iowa.gov](http://www.boee.iowa.gov).

**22.6(3) Requirements.** Applicants must:

a. Hold a preliminary native language teaching authorization and meet the conversion requirements for the native language teaching authorization, or

b. Hold an Iowa teaching license and provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education. The cut score may not be waived by the board. Applicants who hold an Iowa teaching license must also obtain a recommendation from a school district administrator verifying that the school district wishes to hire the applicant. Before the applicant is hired, the school district administrator must verify that a diligent search was completed to hire a fully licensed teacher with the proper endorsement for the position.

**22.6(4) Validity.** This authorization is valid for five years. No Class B licenses may be issued to an applicant holding the native language teaching authorization unless a teaching license is additionally obtained. No additional endorsement areas may be added to the native language teaching authorization.

**22.6(5) Renewal.**

a. Applicants must meet the renewal requirements set forth in rule 282—20.3(272) and 282—subrule 20.5(2).

b. A one-year extension may be issued if all requirements for the renewal of the native language teaching authorization have not been met. This one-year extension is not renewable.

**22.6(6) Revocation and suspension.** Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the native language teaching authorization. If a school district hires an applicant without the proper licensure or endorsement, a complaint may be filed.

[ARC 1721C, IAB 11/12/14, effective 12/17/14]

## **282—22.7(272) School administration manager authorization.**

**22.7(1) Application for authorization.** Effective July 1, 2014, a person who is interested in a school administration manager authorization will be required to apply for an authorization. The following persons must obtain an authorization:

a. A Model 1 SAM, a person who is hired to be a full-time SAM and who is authorized to assume the responsibilities of a SAM;

b. A Model 2 SAM, a person whose position in the school is reconfigured to include the responsibilities of being a SAM and is authorized as a SAM; and

c. A Model 3 SAM, a person who is a secretary/administrative assistant and is also authorized as a SAM.

**22.7(2) Responsibilities.** A school administration manager authorization allows an individual to assist a school administrator in performing noninstructional, administrative-type duties.

**22.7(3) Application process.** Any person interested in the school administration manager authorization shall submit to the board of educational examiners an application which includes a written verification of employment from a school district administrator. Application materials are available from the office of the board of educational examiners online at [www.boee.iowa.gov](http://www.boee.iowa.gov).

**22.7(4) Specific requirements for an initial school administration manager authorization.** Applicants for an initial school administration manager authorization shall have completed the following requirements:

- a. *Education.* Applicants must hold a high school degree or general equivalency diploma.
- b. *Minimum age.* Applicants must have attained a minimum age of 18 years.
- c. *Background check.* Applicants must complete the background check requirements set forth in rule 282—13.1(272).

**22.7(5) Specific requirements for a standard school administration manager authorization.** The initial school administration manager authorization shall be converted to the standard school administration manager authorization provided the following requirements are met.

a. *Training.* A school administration manager shall attend an approved training program at the onset of the individual's hire as a school administration manager. The training for school administration managers is set forth in 281—subrule 82.7(2).

b. *Experience.* An applicant shall complete one year of experience as a school administration manager in an Iowa school. The supervising administrator shall verify this experience and the applicant's completion of the required competencies.

c. *Competencies.* Applicants shall demonstrate completion of or competency in the following:

(1) Each school administration manager shall demonstrate competence in technology appropriate to the school administration manager position. The school administration manager will:

1. Become proficient in the use of the approved time-tracking software tool;
2. Schedule the administrator's time using the approved software, update and reconcile the calendar daily, and attempt to pre-calendar the administrator at or above the administrator's goal; and
3. Regularly schedule, review, and reflect with the administrator on the graphs and data provided through the software.

(2) Each school administration manager shall demonstrate appropriate personal skills. The school administration manager:

1. Is an effective communicator with all stakeholders, including but not limited to colleagues, community members, parents, and students;
  2. Works effectively with employees, students, and stakeholders.
  3. Maintains confidentiality when dealing with student, parent, and staff issues;
  4. Clearly understands the administrator's philosophy of behavior expectations and consequences;
- and
5. Maintains an environment of mutual respect, rapport, and fairness.

**22.7(6) Validity.**

a. The initial school administration manager authorization shall be valid for three years.

b. The standard school administration manager authorization shall be valid for five years.

**22.7(7) Renewal.**

a. The initial school administration manager authorization may be renewed once if the applicant has not previously had employment as a school administration manager but can at the time of application provide evidence of employment as a school administration manager.

b. The standard school administration manager authorization may be renewed upon application and verification of successful completion of the following:

(1) Renewal activities. The applicant for renewal must complete three semester hours of credit through authorized SAM training or online training courses approved by the board of educational examiners in collaboration with the department of education.

(2) Child and dependent adult abuse mandatory reporter trainings. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse mandatory reporter trainings pursuant to 282—subrule 20.3(4).

**22.7(8) Extension.** A one-year extension of the school administration manager authorization may be issued if the applicant does not meet the renewal requirements. The applicant must secure the signature of the superintendent or designee before the extension will be issued.

**22.7(9) Revocation and suspension.** Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the school administration manager authorization.

**22.7(10) Approval of courses.** Each institution of higher education, private college or university, community college, area education agency and professional organization that wishes to offer the semester credit hours for the school administration manager authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 1086C, IAB 10/16/13, effective 11/20/13; ARC 1542C, IAB 7/23/14, effective 8/27/14; ARC 1721C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15; ARC 4634C, IAB 8/28/19, effective 10/2/19]

## **282—22.8(272) iJAG authorization.**

**22.8(1) Authorization.** The Iowa jobs for America’s graduates (iJAG) authorization is provided to noneducators entering the education profession to teach iJAG coursework in grades 7-12.

**22.8(2) Application process.** Any person interested in the iJAG authorization shall submit the application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at [www.boee.iowa.gov](http://www.boee.iowa.gov).

### **22.8(3) Requirements.**

- a. The applicant must have completed a baccalaureate degree.
- b. Background check. The applicant must complete the background check requirements set forth in rule 282—13.1(272).
- c. The applicant must have completed a board of educational examiners-approved iJAG training program consisting of the following components and totaling a minimum of 40 clock hours annually:
  - (1) Instructional methods. Develop skills to effectively deliver project-based instruction in the iJAG core competencies.
  - (2) Curriculum. Develop skills to effectively develop curriculum, projects and other educational opportunities consistent with the goals of iJAG.
  - (3) Measurement and evaluation of programs and students. Analyze student data, administer testing, and monitor the following: basic skills, individualized development plans, attendance, graduation requirements, and course enrollment.
  - (4) Code of ethics. Develop an understanding of how to foster relationships with parents, students, school colleagues, and organizations in the larger community to support students’ learning and development and become aware of the board’s rules of professional practice and code of ethics.
  - (5) Diversity training for educators. Develop an understanding of and sensitivity to the values, beliefs, lifestyles and attitudes of individuals and the diverse groups found in a pluralistic society, including preparation that contributes to the education of individuals with disabilities and the gifted and talented.
- d. The applicant must obtain a recommendation from an iJAG administrator verifying that the organization wishes to hire the applicant.
- e. The applicant must be assigned a mentor by the hiring school district. The mentor must have four years of teaching experience.

**22.8(4) Validity.** This authorization is valid for five years. No Class B license or license based on administrative decision may be issued to an applicant holding the iJAG authorization unless a

teaching license is additionally obtained. No additional endorsement areas may be added to the iJAG authorization.

**22.8(5) *Renewal.*** An applicant for renewal of the iJAG authorization must provide verification of completion of the following:

- a. Required iJAG training as verified through an iJAG administrator.
- b. Child and dependent adult abuse training as stated in 282—subrule 20.3(4).

**22.8(6) *Revocation and suspension.*** Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holder of the iJAG authorization.

[ARC 1322C, IAB 2/19/14, effective 3/26/14; ARC 1721C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15]

**282—22.9(272) Requirements for the career and technical secondary authorization.**

**22.9(1) *Authorization.*** This authorization is provided to noneducators entering the education profession to instruct in occupations and specialty fields that are recognized in career and technical service areas and career cluster areas.

**22.9(2) *Application process.*** Any person interested in the career and technical secondary authorization shall submit the application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at [www.boee.iowa.gov](http://www.boee.iowa.gov).

**22.9(3) *Specific requirements for the initial career and technical secondary authorization.***

a. The applicant must meet the background check requirements for licensure set forth in rule 282—13.1(272).

b. The applicant must obtain a recommendation from a school district administrator verifying that the school district wishes to hire the applicant.

c. Applicants shall meet one of the following qualifications:

- (1) 6,000 hours of recent and relevant experience;
- (2) 4,000 hours of recent and relevant experience if the applicant holds a baccalaureate degree;
- (3) 3,000 hours of recent and relevant experience if the applicant holds an associate's degree in the teaching endorsement area sought, if such a degree is considered terminal for that field of instruction;
- (4) Hold a baccalaureate or graduate degree or closely related degree in the teaching endorsement area sought; or

(5) Hold a baccalaureate degree in any area of study if at least 18 of the credit hours were completed in the teaching endorsement area sought.

Recent and relevant experience shall have been accrued within the ten years prior to the date of application. Experience that does not meet these criteria may be considered at the discretion of the executive director. In subjects for which state registration, certification or licensure is required, the applicant must hold the appropriate license, registration or certificate before the initial career and technical secondary authorization or the career and technical secondary authorization will be issued.

d. The applicant must provide documentation of completion of a code of professional conduct and ethics training approved by the board of educational examiners.

e. Coursework requirements.

(1) Applicants must commit to complete the following requirements within the term of the initial authorization. Coursework must be completed for college credit from a regionally accredited institution.

1. Coursework in the methods and techniques of career and technical education.
2. Coursework in course and curriculum development.
3. Coursework in the measurement and evaluation of programs and students.
4. An approved human relations course.

5. Coursework in the instruction of exceptional learners to include the education of individuals with disabilities and the gifted and talented.

(2) Applicants who believe that their previous college coursework meets the coursework requirements in 22.9(3)“e”(1) may have the specific requirements waived. Transcripts or other supporting data should be provided to a teacher educator at one of the institutions which has an approved

teacher education program. The results of the competency determination shall be forwarded with recommendations to the board of educational examiners. Board personnel will make final determination as to the competencies mastered and cite coursework which yet needs to be completed, if any.

**22.9(4) Validity—initial authorization.** The initial career and technical secondary authorization is valid for three years.

**22.9(5) Renewal.** The initial career and technical secondary authorization may be renewed once if the candidate can demonstrate that coursework progress has been made.

**22.9(6) Conversion.** The initial career and technical secondary authorization may be converted to a career and technical secondary authorization if the applicant has met the following:

- a. Completion of the required coursework set forth in paragraph 22.9(3) “e.”
- b. Documentation of completion of a code of professional conduct and ethics training approved by the board of educational examiners. The training must be completed after the issuance of the initial authorization and no more than three years prior to the date of application.

**22.9(7) Specific requirements for the career and technical secondary authorization.**

- a. This authorization is valid for five years.
- b. An applicant for this authorization must first meet the requirements for the initial career and technical secondary authorization.

c. Renewal requirements for the career and technical secondary authorization. Applicants for renewal must meet the requirements set forth in 282—subrule 20.5(1) and 282—paragraphs 20.5(2) “a” to “d.”

**22.9(8) Revocation and suspension.** Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the initial career and technical secondary authorization or the career and technical secondary authorization. If a school district hires an applicant without a valid license or authorization, a complaint may be filed against the teacher and the superintendent of the school district.

[ARC 2015C, IAB 6/10/15, effective 7/15/15; ARC 3633C, IAB 2/14/18, effective 3/21/18; ARC 5323C, IAB 12/16/20, effective 1/20/21]

**282—22.10(272) Activities administration authorization.** An activities administration authorization allows an individual to administer any pupil activity program in a K-12 school setting.

**22.10(1) Application process.** Any person interested in the activities administration authorization shall submit an application and records of credit to the board of educational examiners for an evaluation of the required courses or contact hours. Application materials are available from the office of the board of educational examiners online at [www.boee.iowa.gov](http://www.boee.iowa.gov).

a. *Requirements.* Applicants for the activities administration authorization shall meet the following requirements:

(1) Degree. A baccalaureate degree or higher in athletic administration or related field from a regionally accredited institution is required.

(2) Credit hours. Applicants must complete credit hours or courses offered by the Leadership Training Institute (LTI) from the National Interscholastic Athletic Administrators Association in the following areas:

1. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of risk management, Title IX, sexual harassment, hazing, Americans with Disabilities Act (ADA), and employment law as they pertain to the role of the activities administrator.

2. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of activities administration foundations including philosophy, leadership, professional programs and activities administration principles, strategies and methods.

3. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of the role of the activities director in supporting and developing sports medicine programs, management of athletic player equipment, concussion assessment and proper fitting of athletic protective equipment, and sports field safety.

4. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of the techniques and theory of coaching concepts and strategies for interscholastic budget and concepts and strategies for interscholastic fundraising.

5. Successful completion of 1 semester credit hour or LTI course, approved by the board, relating to the assessment and evaluation of interscholastic athletic programs and personnel, dealing with challenging personalities, and administration of professional growth programs for interscholastic personnel.

6. Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union.

*b. Minimum age.* Applicants must have attained a minimum age of 21 years.

*c. Background check.* Applicants must complete the background check requirements set forth in rule 282—13.1(272).

**22.10(2) Validity.** The activities administration authorization shall be valid for five years.

**22.10(3) Renewal.**

*a.* The authorization may be renewed upon application and verification of successful completion of the following renewal activities:

(1) Applicants for renewal of an activities administration authorization must complete one of the following professional development options:

1. Document attendance at one state IHSADA convention and one LTI course relating to the knowledge and understanding of professional ethics and legal responsibilities of activities administrators.

2. Complete three LTI courses.

3. Complete 2 semester hours of college credit from a regionally accredited institution.

4. Complete 2 licensure renewal credits from an approved provider.

(2) Applicants for renewal of an activities authorization must complete child and dependent adult abuse training as stated in 282—subrule 20.3(4).

*b.* A one-year extension of the applicant's activities administration authorization may be issued if all requirements for the renewal of the activities administrator authorization have not been met. The one-year extension is nonrenewable.

**22.10(4) Revocation and suspension.** Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the activities administration authorization.

[ARC 1718C, IAB 11/12/14, effective 12/17/14; ARC 2230C, IAB 11/11/15, effective 12/16/15]

**282—22.11(272) Extension.** For authorizations established in this chapter, a one-year extension may be issued if the applicant does not meet the requirements for authorization conversion or renewal. The applicant shall secure the signature of the superintendent or designee of the applicant's employer and shall submit all required materials before the extension will be issued. This one-year extension is nonrenewable.

This rule is intended to implement Iowa Code section 272.31.

[ARC 2121C, IAB 9/2/15, effective 10/7/15]

**282—22.12(272) Orientation and mobility authorization.**

**22.12(1) Authorization.** The holder of this authorization may teach pupils with a visual impairment (see Iowa Code section 256B.2), including those pupils who are deaf-blind.

**22.12(2) Initial orientation and mobility authorization.** The initial authorization is valid for three years. An applicant must:

*a.* Hold a baccalaureate or master's degree from an approved state and regionally accredited program in orientation and mobility or equivalent coursework.

*b.* Have completed an approved human relations component.

*c.* Have completed the exceptional learner program, which must include preparation that contributes to the education of students with disabilities and students who are gifted and talented.

*d.* Have completed a minimum of 21 semester credit hours in the following areas:

(1) Medical aspects of blindness and visual impairment, including sensory motor.

(2) Psychosocial aspects of blindness and visual impairment.

- (3) Child development.
  - (4) Concept development.
  - (5) History of orientation and mobility.
  - (6) Foundations of orientation and mobility.
  - (7) Orientation and mobility instructional methods and assessments.
  - (8) Techniques of orientation and mobility.
  - (9) Research or evidence-based practices in orientation and mobility.
  - (10) Professional issues in orientation and mobility, including legal issues.
- e. Have completed at least 350 hours of fieldwork and training under the supervision of the university program.

f. Have completed the background check requirements set forth in rule 282—13.1(272).

**22.12(3) Standard orientation and mobility license.** An applicant must:

- a. Complete the requirements set forth in subrule 22.12(2).
- b. Verify successful completion of a three-year probationary period.

**22.12(4) Renewal of orientation and mobility license.** Renewal requirements for the career and technical secondary authorization. Applicants must meet the renewal requirements set forth in rule 282—20.3(272) and 282—subrule 20.5(2).

**22.12(5) Exception.** An orientation and mobility specialist is not eligible for any administrator license in either general education or special education.

[ARC 5322C, IAB 12/16/20, effective 1/20/21]

These rules are intended to implement Iowa Code chapter 272.

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[Filed ARC 5321C (Notice ARC 5216C, IAB 10/7/20), IAB 12/16/20, effective 1/20/21]

- <sup>1</sup> December 14, 2016, effective date of 22.1(2) "a"(7) and 22.1(4) "a"(4) [ARC 2793C, Item 2] delayed until the adjournment of the 2017 General Assembly by the Administrative Rules Review Committee at its meeting held December 13, 2016.
- <sup>2</sup> January 6, 2021, effective date of 22.2 [ARC 5303C, Item 2] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held December 8, 2020.

CHAPTER 24  
PARAEDUCATOR CERTIFICATES  
[Prior to 1/14/09, see Educational Examiners Board[282] Ch 22]

**282—24.1(272) Paraeducator certificates.** Iowa paraeducator certificates are issued upon application filed on a form provided by the board of educational examiners. Applicants must complete the background check requirements set forth in rule 282—13.1(272).  
[ARC 2230C, IAB 11/11/15, effective 12/16/15]

**282—24.2(272) Approved paraeducator certificate programs.** An applicant for an initial paraeducator certificate who completes the paraeducator preparation program from a recognized Iowa paraeducator approved program shall have the recommendation from the designated certifying official at the recognized area education agency, local education agency, community college, or institution of higher education where the preparation was completed. A recognized Iowa paraeducator approved program is one which has its program of preparation approved by the state board of education according to standards established by the board of educational examiners.

**282—24.3(272) Prekindergarten through grade 12 paraeducator generalist certificate.**

**24.3(1)** Applicants must possess a minimum of a high school diploma or a graduate equivalent diploma.

**24.3(2)** Qualifications or criteria for the granting or revocation of a certificate or the determination of an individual's professional standing shall not include membership or nonmembership in any teacher or paraeducator organization.

**24.3(3)** Applicants shall have successfully completed at least 90 clock hours of training in the areas of behavior management, exceptional child and at-risk child behavior, collaboration skills, interpersonal relations skills, child and youth development, technology, and ethical responsibilities and behavior.

**24.3(4)** Applicants shall have successfully completed the following list of competencies.

*a. Foundations.* Under the supervision of a licensed education professional, the paraeducator will:

- (1) Recognize the different developmental stages of students.
- (2) Believe every student can learn.
- (3) Recognize that each learner has unique learning needs that may require accommodations.
- (4) Demonstrate knowledge of the common core, including competence in reading, writing and math.

(5) Function in a manner that demonstrates a positive regard for the distinction between roles and responsibilities of paraeducators and other professionals, including respecting the teacher as supervisor and seeing the teacher as ultimately responsible for the education and behavior of the students.

*b. Learning environment.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Follow the prescribed health, safety, and emergency school and classroom policy and procedures.

- (2) Organize materials to support teaching and learning.
- (3) Facilitate the integration of students with diverse needs in various settings.
- (4) Assist with special health services, under the supervision of a licensed health care provider.
- (5) Promote a safe and positive learning environment.
- (6) Function in various instructional settings (e.g., large group, small group, tutoring).

*c. Content and instruction.* Under the supervision of a licensed education professional, the paraeducator will:

- (1) Assist with learning activities and opportunities to accomplish instructional objectives.
- (2) Support high expectations that are shared, clearly defined and appropriate.
- (3) Monitor progress and document and report objective observations that inform instructional decisions.
- (4) Effectively use verbal and nonverbal forms of communication with students.
- (5) Assist with the implementation and use of instructional and assistive technology.

*d. Emotional and behavioral.* Under the supervision of a licensed education professional, the paraeducator will:

- (1) Assist in modeling and teaching specific appropriate behaviors, social skills, and procedures that facilitate safety and learning in various environments.
- (2) Assist in the implementation of individualized behavior management plans.
- (3) Document and report objective observations on student behaviors.
- (4) Assist in modifying the learning environment to manage behavior and social skills.
- (5) Recognize that there is a cause or reason for misbehavior and assist in determining the cause or reason.
- (6) Recognize, address, and report bullying.
- (7) Recognize and report atypical emotional behavior.

*e. Professional relationships.* Under the supervision of a licensed education professional, the paraeducator will:

- (1) Demonstrate a commitment to work as an effective team member.
- (2) Foster a professional and caring relationship with each student's family.
- (3) Develop and maintain positive and professional relationships with students.

*f. Ethical and professional practice.* Under the supervision of a licensed education professional, the paraeducator will:

- (1) Follow ethical practices for confidential information.
- (2) Participate in ongoing professional development.
- (3) Accept and apply constructive feedback.
- (4) Abide by the Iowa code of ethics and professional practice rules of the board of educational examiners and rules of the Iowa department of education.
- (5) Demonstrate the ability to separate personal issues from one's responsibilities in the workplace.
- (6) Maintain a high level of competency and integrity.
- (7) Share information regarding students' performance, behavior, or program with students' parents or guardians only as directed by the supervising teacher or educator.
- (8) Be aware of personal biases and beliefs and refrain from discriminatory practices based on a student's disability, race, creed, color, religion, age, sex, sexual orientation, gender identity, disability, marital status, or national origin.
- (9) Demonstrate ethical behavior when supporting students with graded activities, quizzes, and tests.
- (10) Abide by Iowa law regarding the use of restraint and seclusion.
- (11) Recognize that the paraeducator may not be given primary responsibility for the education of an individual student(s).
- (12) Recognize that instructional decisions are made by the individualized education program (IEP) team for students with disabilities and that any changes to instruction, accommodations, supports, and services cannot be made outside the IEP team.

**24.3(5)** An applicant for a certificate under these rules shall demonstrate that the requirements of the certificate have been met, and the burden of proof shall be on the applicant.

[ARC 1325C, IAB 2/19/14, effective 3/26/14]

**282—24.4(272) Paraeducator area of concentration.** An area of concentration is not required but optional. Applicants must currently hold or have previously held an Iowa paraeducator generalist certificate. Applicants may complete one or more areas of concentration but must complete at least 45 clock hours in each area of concentration, with the exception of the substitute authorization.

**24.4(1) Early childhood—prekindergarten through grade 3.** The paraeducator shall successfully complete the following list of competencies:

*a. Foundations.* Under the supervision of a licensed education professional, the paraeducator will:

- (1) Know and understand young children's typical and atypical developmental stages and their needs at each stage.
- (2) Recognize multiple influences on young children's development and learning.

(3) Recognize developmentally appropriate practices for interactions with and the education of young children.

*b. Learning environment.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Describe the elements of environments that support children's learning and well-being.

(2) Demonstrate skills, strategies, and activities involving an individual child or small groups of children to reinforce instruction from a licensed teacher.

(3) Set up environments that are safe, inclusive, and responsive to children's developmental strengths, interests and needs.

*c. Content and instruction.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Recognize effective strategies and techniques to stimulate cognitive, physical, social, emotional, and language development for each child in a developmentally appropriate way.

(2) Demonstrate knowledge and understanding of the Iowa Early Learning Standards by describing what young children know and do in order to provide experiences and interactions to promote learning.

(3) Gather information, as instructed by the classroom teacher, about an individual child's development, learning and behaviors including observing, recording, and charting.

*d. Emotional and behavioral competencies.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Gather information, as instructed by the classroom teacher, to identify children's skills and provide appropriate levels of support needed for the children to access, participate and engage in activities.

(2) Implement teacher-designed intervention plans to promote positive social relationships, interactions and behaviors that are age- and developmentally appropriate.

*e. Professional relationships.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate the ability to collaborate with an educational team to systematically and regularly exchange information to support problem solving, planning, and the implementing of instruction and individualized interventions.

(2) Demonstrate the ability to establish relationships with all children and their families that are respectful, supportive and sensitive.

(3) Demonstrate a collaborative relationship with the teacher to support children's learning.

(4) Demonstrate knowledge of community services and agencies available to assist families.

*f. Ethical and professional practice.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate knowledge of Iowa Early Learning Standards and the preschool program standards being implemented, which may include the Iowa Quality Preschool Program Standards, Head Start Program Performance Standards and National Association for the Education of Young Children (NAEYC) Program Standards and Accreditation Criteria.

(2) Reserved.

**24.4(2) Special needs—prekindergarten through grade 12.** The paraeducator shall successfully complete the following list of competencies.

*a. Foundations.* Under the supervision of a licensed education professional, the paraeducator will demonstrate an understanding of an IEP.

*b. Learning environment.* Under the supervision of a licensed education professional, the paraeducator will demonstrate an understanding of the value of serving children and youth with disabilities and special needs in inclusive settings.

*c. Content and instruction.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Implement the activities assigned by a teacher to meet the goals and objectives in an IEP.

(2) Assist in academic subjects through use of lesson plans and instructional strategies developed by teachers and other professional support staff.

(3) Gather and maintain data about the performance of individual students and confer with special and general education practitioners about student schedules, instructional goals, progress, and performance.

(4) Operate computers and use assistive technology and adaptive equipment that will enable students with special needs to participate more fully in general education.

*d. Emotional and behavioral.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Gather and maintain data about the behavior of individual students and confer with special and general education practitioners about student schedules, instructional goals, progress, and performance.

(2) Use appropriate instructional procedures and reinforcement techniques as specified in the IEP or by the behavior team.

*e. Professional relationships.* Under the supervision of a licensed education professional, the paraeducator will, if asked, participate as a member of the IEP team responsible for developing service plans and educational objectives.

**24.4(3) English as a second language—prekindergarten through grade 12.** The paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

*a.* Operate computers and use technology that will enable students to participate effectively in the classroom.

*b.* Work with the classroom teacher as collaborative partners.

*c.* Demonstrate knowledge of the role and use of primary language of instruction in accessing English for academic purposes.

*d.* Demonstrate knowledge of instructional methodologies for second language acquisition.

*e.* Communicate and work effectively with parents or guardians of English as a second language students in their primary language.

*f.* Demonstrate knowledge of appropriate translation and interpretation procedures.

**24.4(4) Career and transitional programs—grades 5 through 12.** The paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

*a.* Assist in the implementation of career and transitional programs.

*b.* Assist in the implementation of appropriate behavior management strategies for career and transitional students and those students who may have special needs.

*c.* Assist in the implementation of assigned performance and behavior assessments including observation, recording, and charting for career and transitional students and those students who may have special needs.

*d.* Provide training at job sites using appropriate instructional interventions.

*e.* Participate in preemployment, employment, or transitional training in classrooms or at off-campus sites.

*f.* Communicate effectively with employers and employees at work sites and with personnel or members of the public in other transitional learning environments.

**24.4(5) School library media—prekindergarten through grade 12.** The school library media paraeducator shall successfully complete the following list of competencies so that, under the direct supervision and direction of a qualified school library supervisor or school librarian, the paraeducator will be able to:

*a.* Be aware of, implement, and support the goals, objectives, and policies of the school library media program.

*b.* Assist the school library supervisor or school librarian in general operations, such as processing materials, circulating materials, performing clerical tasks, assisting students and staff, and working with volunteers and student helpers, and to understand the role of the paraeducator in the library setting in order to provide efficient, equitable, and effective library services.

*c.* Demonstrate knowledge of library technical services including, but not limited to, cataloging, processing, acquisitions, routine library maintenance, automation and new technologies.

- d. Be aware of and support the integration of literacy initiatives and content area standards, e.g., visual information and technology in support of the curriculum.
- e. Be aware of the role school libraries play in improving student achievement, literacy, and lifelong learning.
- f. Demonstrate an understanding of ethical issues related to school libraries, such as copyright, plagiarism, privacy, diversity, confidentiality, and freedom of speech.
- g. Assist in the daily operations of the school library program, such as shelving, working with volunteers and student helpers, inventory, materials repair and maintenance.
- h. Exhibit welcoming behaviors to all library patrons and visitors to encourage use of the library and its resources.
- i. Demonstrate knowledge of the school library collection and the availability of other resources that will meet individual student information or research needs.
- j. Demonstrate a general knowledge of basic technology skills and assist in troubleshooting basic hardware and software problems.

**24.4(6)** *Speech-language pathology (SLP)—prekindergarten through grade 12.* The speech-language pathology paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified speech-language pathologist, the paraeducator will be able to:

- a. Understand the roles and responsibilities of the speech-language pathology paraeducator.
- b. Demonstrate a basic understanding of the four areas of communication, including articulation, language, fluency, and voice, and how they occur through typical development.
- c. Demonstrate an understanding of articulation/phonological disabilities.
- d. Demonstrate an understanding of language disabilities.
- e. Use appropriate instructional procedures and reinforcement techniques when working with children with articulation/phonological disabilities.
- f. Use appropriate instructional procedures and reinforcement techniques when working with children with language disabilities.
- g. Gather information as directed by the speech-language pathologist regarding the performance of children, including recording and charting responses.

**24.4(7)** *Vision impairments—prekindergarten through grade 12.*

- a. Demonstrate knowledge of the impact of vision loss on learning and concept development for students who are blind or visually impaired.
  - (1) Demonstrate introductory knowledge of expanded core curriculum (ECC) and the ability to support ECC skills as directed by the supervising professional.
  - (2) Demonstrate introductory knowledge of functional vision assessments (FVA) and learning media assessments (LMA) of students who have vision impairments.
- b. Demonstrate knowledge of and skills in technology appropriate to the needs of students with vision impairments.
  - (1) Operate and use assistive technology that supports students who have vision impairments.
  - (2) Support and strengthen each student's capability to access and utilize assistive technology.
- c. Demonstrate introductory knowledge of instructional strategies unique to students who have vision impairments.
  - (1) Demonstrate the ability to adapt educational materials by using varied learning media as determined by student needs.
  - (2) Demonstrate an introductory knowledge of Braille in relation to identified or expressed student needs or both.
  - (3) Demonstrate introductory skills in operating transcription software and equipment.
- d. Demonstrate introductory knowledge of motor skills, movement, orientation, and mobility for students with vision impairments.
- e. Demonstrate knowledge of the role of paraeducators in student plans including individualized education programs (IEPs) and individualized family service plans (IFSPs).

*f.* Demonstrate knowledge about and skills in fostering independence, self-determination, social skills, self-advocacy, and appropriate behaviors for students with vision impairments.

*g.* Demonstrate professionalism and ethical practices, including appropriate communication skills in relation to students with vision impairments and the students' service providers and families.

**24.4(8) Autism spectrum disorders.** Under the direction and supervision of a qualified classroom teacher, the paraeducator shall successfully complete the following list of competencies.

*a. Foundations.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate an understanding of the components of education plans (individualized education program (IEP), behavior intervention plan (BIP), functional behavioral analysis (FBA), and Section 504 Plan).

(2) Identify common characteristics of students with autism spectrum disorder (communication, social, restricted interest and behavior) and how these characteristics compare to those of typical children.

*b. Learning environment.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Assist in structuring the environment to meet the needs of students with autism spectrum disorder.

(2) Implement with integrity schedules and educational programs prescribed by the licensed teacher.

*c. Content and instruction.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Implement the educational, academic, and communication accommodations, adaptations, and supports assigned by a teacher.

(2) Provide opportunities for students with autism spectrum disorders to initiate and respond to large interactions and small interactions in academic settings.

(3) Provide opportunities for students with autism spectrum disorders to initiate, respond to, and participate in interactions in large groups and small groups in authentic situations.

(4) Gather and maintain data on student academic performance as directed by a licensed teacher.

(5) Assist educational staff in developing accommodations and adaptations and self-determination skills to increase student independence.

*d. Emotional and behavioral.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Understand and identify the function of a behavior (e.g., antecedents, behaviors, consequences).

(2) Collect data on student behavior and related environmental stimuli, based on the concepts of antecedents, behaviors and consequences.

(3) Implement antecedent strategies on student behavior, as defined by the licensed educator.

(4) Reinforce and practice replacement behaviors, as defined by the licensed educator.

(5) Respond to problem behaviors in a consistent manner, as defined by the licensed educator.

(6) Gather and maintain data on student social and behavioral performance, as directed by a licensed teacher.

*e. Professional relationships.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate the ability to support the viewpoints and perspectives of students with autism and be empathetic to the students' learning styles.

(2) Respond to challenging behaviors in a respectful, empathetic manner.

*f. Ethical and professional practice.* Under the supervision of a licensed education professional, the paraeducator will:

(1) Know and understand the expectations of confidentiality in regard to student information and social media usage.

(2) Know and understand the legal constructs of the IEP and the Individuals with Disabilities Education Act (IDEA).

**24.4(9) Paraeducator substitute authorization.** An individual who holds a paraeducator certificate and completes the substitute authorization requirements set forth in rule 282—22.2(272) but who does

not meet the degree requirement in subparagraph 22.2(1) “a”(2) is authorized to substitute only in the special education classroom in which the individual paraeducator is employed.

[ARC 8405B, IAB 12/16/09, effective 1/20/10; ARC 9204B, IAB 11/3/10, effective 12/8/10; ARC 1325C, IAB 2/19/14, effective 3/26/14; ARC 2529C, IAB 5/11/16, effective 6/15/16; ARC 3197C, IAB 7/5/17, effective 8/9/17; ARC 5303C, IAB 12/2/20, effective 1/6/21; see Delay note at end of chapter]

**282—24.5(272) Prekindergarten through grade 12 advanced paraeducator certificate.** Applicants for the prekindergarten through grade 12 advanced paraeducator certificate shall have met the following requirements:

**24.5(1)** Currently hold or have previously held an Iowa paraeducator generalist certificate.

**24.5(2)** Possess an associate’s degree or have earned 62 semester hours of college coursework from a regionally accredited institution of higher education.

**24.5(3)** Complete a minimum of 2 semester hours of coursework involving at least 100 clock hours of a supervised practicum with children and youth. These 2 semester hours of practicum may be part of an associate’s degree or part of the earned 62 semester hours of college coursework.

**282—24.6(272) Renewal requirements.**

**24.6(1)** The paraeducator certificate may be renewed upon application, payment of a renewal fee as established in 282—Chapter 12, and verification of successful completion of coursework totaling three units in any combination listed below.

*a.* One unit may be earned for each semester hour of credit which leads to the completion of the requirements for an area of concentration not currently held.

*b.* One unit may be earned for each hour of credit that will assist a paraeducator to demonstrate the knowledge of and the ability to assist in reading, writing, or mathematics.

*c.* One unit may be earned for each hour of credit completed which supports either the building’s or district’s career development plan.

*d.* One unit may be earned for each semester hour of college credit.

**24.6(2)** All applicants renewing a paraeducator certificate must submit documentation of completion of the child and dependent adult abuse trainings pursuant to 282—subrule 20.3(4).

[ARC 4634C, IAB 8/28/19, effective 10/2/19]

**282—24.7(272) Issue date on original certificate.** A certificate is valid only from and after the date of issuance.

**282—24.8(272) Validity.** The paraeducator certificate shall be valid for five years.

**282—24.9(272) Certificate application fee.** All fees are nonrefundable.

**24.9(1)** *Issuance of certificates.* The fee for the issuance of the paraeducator certificate shall be as established in 282—Chapter 12.

**24.9(2)** *Adding areas of concentration.* The fee for the addition of each area of concentration to a paraeducator certificate, following the issuance of the initial paraeducator certificate and any area(s) of concentration, shall be as established in 282—Chapter 12.

These rules are intended to implement Iowa Code chapter 272.

[Filed 12/24/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]

[Filed ARC 8405B (Notice ARC 8117B, IAB 9/9/09), IAB 12/16/09, effective 1/20/10]

[Filed ARC 9204B (Notice ARC 8960B, IAB 7/28/10), IAB 11/3/10, effective 12/8/10]

[Filed ARC 1325C (Notice ARC 1233C, IAB 12/11/13), IAB 2/19/14, effective 3/26/14]

[Filed ARC 2230C (Notice ARC 2130C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]

[Filed ARC 2529C (Notice ARC 2410C, IAB 2/17/16), IAB 5/11/16, effective 6/15/16]

[Filed ARC 3197C (Notice ARC 3047C, IAB 5/10/17), IAB 7/5/17, effective 8/9/17]

[Filed ARC 4634C (Notice ARC 4504C, IAB 6/19/19), IAB 8/28/19, effective 10/2/19]

[Filed ARC 5303C (Notice ARC 5169C, IAB 9/9/20), IAB 12/2/20, effective 1/6/21]<sup>1</sup>

<sup>1</sup> January 6, 2021, effective date of 24.4 [ARC 5303C, Item 3] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held December 8, 2020.

CHAPTER 2  
COMMISSION PROCEDURE FOR RULE MAKING  
[Prior to 8/10/88, see College Aid Commission, 245—13.1 and 13.2]

**283—2.1(17A) Applicability.** Except to the extent otherwise expressly provided by statute, all rules adopted by the commission are subject to the provisions of Iowa Code chapter 17A, the Iowa administrative procedure Act, and the provisions of this chapter.

**283—2.2(17A) Advice on possible rules before notice of proposed rule adoption.** In addition to seeking information by other methods, the commission may, before publication of a Notice of Intended Action under Iowa Code section 17A.4(1)“a,” solicit comments from the public on a subject matter of possible rule making by the commission by causing notice to be published in the Iowa Administrative Bulletin of the subject matter and indicating where, when, and how persons may comment.

**283—2.3(17A) Public rule-making docket.**

**2.3(1) Docket maintained.** The commission shall maintain a current public rule-making docket.

**2.3(2) Anticipated rule making.** The rule-making docket shall list each anticipated rule-making proceeding. A rule-making proceeding is deemed “anticipated” from the time a draft of proposed rules is distributed for internal discussion within the commission. For each anticipated rule-making proceeding the docket shall contain a listing of the precise subject matter which may be submitted for consideration by the executive director for subsequent proposal under the provisions of Iowa Code section 17A.4(1)“a,” the name and address of commission personnel with whom persons may communicate with respect to the matter, and an indication of the present status within the commission of that possible rule. The commission also may include in the docket other subjects upon which public comment is desired.

**2.3(3) Pending rule-making proceedings.** The rule-making docket shall list each pending rule-making proceeding. A rule-making proceeding is pending from the time it is commenced, by publication in the Iowa Administrative Bulletin of a Notice of Intended Action pursuant to Iowa Code section 17A.4(1)“a,” to the time it is terminated, by publication of a Notice of Termination in the Iowa Administrative Bulletin or the rule becoming effective. For each rule-making proceeding, the docket shall indicate:

- a. The subject matter of the proposed rule;
- b. A citation to all published notices relating to the proceeding;
- c. Where written submissions on the proposed rule may be inspected;
- d. The time during which written submissions may be made;
- e. The names of persons who have made written requests for an opportunity to make oral presentations on the proposed rule, where those requests may be inspected, and where and when oral presentations may be made;
- f. Whether a written request for the issuance of a regulatory analysis, or a concise statement of reasons, has been filed, whether such an analysis or statement or a fiscal impact statement has been issued, and where any such written request, analysis, or statement may be inspected;
- g. The current status of the proposed rule and any commission determinations with respect thereto;
- h. Any known timetable for commission decisions or other action in the proceeding;
- i. The date of the rule’s adoption;
- j. The date of the rule’s filing, indexing, and publication;
- k. The date on which the rule will become effective; and
- l. Where the rule-making record may be inspected.

**283—2.4(17A) Notice of proposed rule making.**

**2.4(1) Contents.** At least 35 days before the adoption of a rule the commission shall cause Notice of Intended Action to be published in the Iowa Administrative Bulletin. The Notice of Intended Action shall include:

- a. A brief explanation of the purpose of the proposed rule;

- b. The specific legal authority for the proposed rule;
- c. Except to the extent impracticable, the text of the proposed rule;
- d. Where, when, and how views may be presented on the proposed rule; and
- e. Where, when, and how an oral proceeding may be demanded on the proposed rule if the notice does not already provide for one.

Where inclusion of the complete text of a proposed rule in the Notice of Intended Action is impracticable, the commission shall include in the notice a statement fully describing the specific subject matter of the omitted portion of the text of the proposed rule, the specific issues to be addressed by the omitted text of the proposed rule, and the range of possible choices being considered by the commission for the resolution of each of those issues.

**2.4(2) *Incorporation by reference.*** A proposed rule may incorporate other materials by reference only if it complies with all of the requirements applicable to the incorporation by reference of other materials in an adopted rule that are contained in subrule 2.12(2) of this chapter.

**2.4(3) *Copies of notices.*** Persons desiring to receive copies of all future Notices of Intended Action must file with the commission a written request indicating the name and address to which such notices should be sent. Within seven days after submission of a Notice of Intended Action to the administrative rules coordinator for publication in the Iowa Administrative Bulletin, the commission shall mail or electronically transmit a copy of that notice to those persons who have filed a written request for either mailing or electronic transmittal with the commission for Notices of Intended Action. The written request shall be accompanied by payment of the subscription price which may cover the full cost of the subscription service, including its administrative overhead and the cost of copying and mailing the Notices of Intended Action for a period of one year. Interested persons may also subscribe to the service provided at <https://www.legis.iowa.gov/Subscribe/agencyChanges.aspx> to receive rule-making information regarding the commission.

[ARC 1490C, IAB 6/11/14, effective 7/30/14]

### **283—2.5(17A) Public participation.**

**2.5(1) *Written comments.*** For at least 20 days after publication of Notice of Intended Action, arguments, data, and views may be submitted in writing on the proposed rule. Such written submissions should identify the proposed rule to which they relate and should be submitted to Executive Director, College Student Aid Commission, 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608 or to the person designated in the Notice of Intended Action.

**2.5(2) *Oral proceedings.*** The commission may, at any time, schedule an oral proceeding on a proposed rule. The commission shall schedule an oral proceeding on a proposed rule if, within 20 days after the published Notice of Intended Action, a written request for an opportunity to make oral presentations is submitted to the commission by the administrative rules review committee, a governmental subdivision, an agency, an association having not less than 25 members, or at least 25 persons. That request must contain the following additional information:

a. A request by one or more individual persons must be signed by each individual and must include the address and telephone number of each individual.

b. A request by an association must be signed by an officer or designee of the association, must contain a statement that the association has at least 25 members, and must include the address and telephone number of the person signing the request.

c. A request by an agency or governmental subdivision must be signed by an official having authority to act on behalf of the entity and must contain the address and telephone number of the person signing the request.

**2.5(3) *Conduct of oral proceedings.***

a. *Applicability.* This subrule applies only to those oral rule-making proceedings in which an opportunity to make oral presentations is authorized or required by Iowa Code section 17A.4(1) “b” as amended by 1998 Iowa Acts, chapter 1202, section 8, or this chapter.

b. *Scheduling and notice.* An oral proceeding on a proposed rule may be held in one or more locations and shall not be held earlier than 20 days after notice of its location and time is published in the

Iowa Administrative Bulletin. That notice shall identify the proposed rule by ARC number and citation to the Iowa Administrative Bulletin.

*c. Presiding officer.* The commission, a member of the commission, or another person designated by the commission who will be familiar with the substance of the proposed rule, shall preside at the oral proceeding on a proposed rule. If the commission does not preside, the presiding officer shall prepare a memorandum for consideration by the commission summarizing the contents of the presentations made at the oral proceeding unless the commission determines that such a memorandum is unnecessary because the commission will personally listen to or read the entire transcript of the oral proceeding.

*d. Conduct of proceeding.* At an oral proceeding on a proposed rule, oral statements and documentary and physical submissions may be made including data, views, comments, or arguments concerning the proposed rule. Persons wishing to make oral presentations at such a proceeding are encouraged to notify the commission at least one business day prior to the proceeding and indicate the general subject of the presentations. At the proceeding, those who participate shall indicate their names and addresses, identify any persons or organizations they represent, and provide any other information relating to their participation deemed appropriate by the presiding officer. Oral proceedings shall be open to the public and shall be recorded by stenographic or electronic means.

(1) At the beginning of the oral proceeding, the presiding officer shall give a brief synopsis of the proposed rule, a statement of the statutory authority for the proposed rule, and the reasons for the commission decision to propose the rule. The presiding officer may place time limitations on individual oral presentations when necessary to ensure the orderly and expeditious conduct of the oral proceeding. To encourage joint oral presentations and to avoid repetition, additional time may be provided for persons whose presentations represent the views of other individuals as well as their own views.

(2) Persons making oral presentations are encouraged to avoid restating matters submitted in writing.

(3) To facilitate the exchange of information, the presiding officer may, where time permits, open the floor to questions or general discussion.

(4) The presiding officer shall have the authority to take any reasonable action necessary for the orderly conduct of the meeting.

(5) Physical and documentary submissions presented by participants in the oral proceeding shall be submitted to the presiding officer. Such submissions become the property of the commission.

(6) The oral proceeding may be continued by the presiding officer to a later time without notice other than by announcement at the hearing.

(7) Participants in an oral proceeding shall not be required to take an oath or to submit to cross-examination. However, the presiding officer in an oral proceeding may question participants and permit the questioning of participants by other participants about any matter relating to that rule-making proceeding, including any prior written submissions made by those participants in that proceeding; but no participant shall be required to answer any question.

(8) The presiding officer in an oral proceeding may permit rebuttal statements and request the filing of written statements subsequent to the adjournment of the oral presentations.

**2.5(4) Additional information.** In addition to receiving written comments and oral presentations on a proposed rule according to the provisions of this rule, the commission may obtain information concerning a proposed rule through any other lawful means deemed appropriate.

**2.5(5) Accessibility.** The commission shall schedule oral proceedings in rooms accessible to, and functional for, persons with physical disabilities. Persons who have special requirements should contact the administrative secretary at College Student Aid Commission, 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608 in advance to arrange access or other needed services.

[ARC 1490C, IAB 6/11/14, effective 7/30/14; Editorial change: IAC Supplement 2/10/21]

### **283—2.6(17A) Regulatory analysis.**

**2.6(1) Definition of small business.** A small business is defined in Iowa Code section 17A.4A(7).

**2.6(2) Mailing list.** Small businesses or organizations of small businesses may be registered on the commission's small business impact list by making a written application addressed to College Student

Aid Commission, 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608. The application for registration shall state:

- a. The name of the small business or organization of small businesses;
- b. Its address;
- c. The name of a person authorized to transact business for the applicant;
- d. A description of the applicant's business or organization. An organization representing 25 or more persons who qualify as a small business shall indicate that fact.
- e. Whether the registrant desires copies of Notices of Intended Action at cost, or desires advance notice of the subject of all or some specific category of proposed rule making affecting small business.

The commission may, at any time, request additional information from the applicant to determine whether the applicant is qualified as a small business or as an organization of 25 or more small businesses. The commission may periodically send a letter to each registered small business or organization of small businesses asking whether that business or organization wants to remain on the registration list. The name of a small business or organization of small businesses will be removed from the list if a negative response is received or if no response is received within 30 days after the letter is sent.

**2.6(3) *Time of mailing.*** Within seven days after submission of a Notice of Intended Action to the administrative rules coordinator for publication in the Iowa Administrative Bulletin, the commission shall mail to all registered small businesses or organizations of small businesses, in accordance with their request, either a copy of the Notice of Intended Action or notice of the subject of that proposed rule making. In the case of a rule that may have an impact on small business adopted in reliance upon Iowa Code section 17A.4(2), the commission shall mail notice of the adopted rule to registered businesses or organizations prior to the time the adopted rule is published in the Iowa Administrative Bulletin.

**2.6(4) *Qualified requesters for regulatory analysis—economic impact.*** The commission shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4A(2a) after a proper request from:

- a. The administrative rules coordinator;
- b. The administrative rules review committee.

**2.6(5) *Qualified requesters for regulatory analysis—business impact.*** The commission shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4A(2b) after a proper request from:

- a. The administrative rules review committee;
- b. The administrative rules coordinator;
- c. At least 25 or more persons who sign the request provided that each represents a different small business;
- d. An organization representing at least 25 small businesses. That organization shall list the names, addresses and telephone numbers of not less than 25 small businesses it represents.

**2.6(6) *Time period for analysis.*** Upon receipt of a timely request for a regulatory analysis the commission shall adhere to the time lines described in Iowa Code section 17A.4A(4).

**2.6(7) *Contents of request.*** A request for a regulatory analysis is made when it is mailed or delivered to the commission. The request shall be in writing and satisfy the requirements of Iowa Code section 17A.4A(1).

**2.6(8) *Contents of concise summary.*** The contents of the concise summary shall conform to the requirements of Iowa Code section 17A.4A(4,5).

**2.6(9) *Publication of a concise summary.*** The commission shall make available, to the maximum extent feasible, copies of the published summary in conformance with Iowa Code section 17A.4A(5).

**2.6(10) *Regulatory analysis contents—rules review committee or rules coordinator.*** When a regulatory analysis is issued in response to a written request from the administrative rules review committee, or the administrative rules coordinator, the regulatory analysis shall conform to the requirements of Iowa Code section 17A.4A(2a), unless a written request expressly waives one or more of the items listed in the section.

**2.6(11) *Regulatory analysis contents—substantial impact on small business.*** When a regulatory analysis is issued in response to a written request from the administrative rules review committee,

the administrative rules coordinator, at least 25 persons signing that request who each qualify as representatives of a small business or by an organization representing at least 25 small businesses, the regulatory analysis shall conform to the requirements of Iowa Code section 17A.4A(2b).  
[ARC 1490C, IAB 6/11/14, effective 7/30/14; Editorial change: IAC Supplement 2/10/21]

**283—2.7(17A,25B) Fiscal impact statement.**

**2.7(1)** A proposed rule that mandates additional combined expenditures exceeding \$100,000 by all affected political subdivisions or agencies and entities which contract with political subdivisions to provide services must be accompanied by a fiscal impact statement outlining the costs associated with the rule. A fiscal impact statement must satisfy the requirements of Iowa Code section 25B.6.

**2.7(2)** If the commission determines, at the time it adopts a rule, that the fiscal impact statement upon which the rule is based contains errors, the commission shall, at the same time, issue a corrected fiscal impact statement and publish the corrected fiscal impact statement in the Iowa Administrative Bulletin.

**283—2.8(17A) Time and manner of rule adoption.**

**2.8(1)** *Time of adoption.* The commission shall not adopt a rule until the period for making written submissions and oral presentations has expired. Within 180 days after the later of the publication of the Notice of Intended Action, or the end of oral proceedings thereon, the commission shall adopt a rule pursuant to the rule-making proceeding or terminate the proceeding by publication of a notice to that effect in the Iowa Administrative Bulletin.

**2.8(2)** *Consideration of public comment.* Before the adoption of a rule, the commission shall consider fully all of the written submissions and oral submissions received in that rule-making proceeding or any memorandum summarizing such oral submissions, and any regulatory analysis or fiscal impact statement issued in that rule-making proceeding.

**2.8(3)** *Reliance on commission expertise.* Except as otherwise provided by law, the commission may use its own experience, technical competence, specialized knowledge, and judgment in the adoption of a rule.

**283—2.9(17A) Variance between adopted rule and published notice of proposed rule adoption.**

**2.9(1)** The commission shall not adopt a rule that differs from the rule proposed in the Notice of Intended Action on which the rule is based unless:

- a.* The differences are within the scope of the subject matter announced in the Notice of Intended Action and are in character with the issues raised in that notice; and
- b.* The differences are a logical outgrowth of the contents of that Notice of Intended Action and the comments submitted in response thereto; and
- c.* The Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question.

**2.9(2)** In determining whether the Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question, the commission shall consider the following factors:

- a.* The extent to which persons who will be affected by the rule should have understood that the rule-making proceeding on which it is based could affect their interests;
- b.* The extent to which the subject matter of the rule or the issues determined by the rule are different from the subject matter or issues contained in the Notice of Intended Action; and
- c.* The extent to which the effects of the rule differ from the effects of the proposed rule contained in the Notice of Intended Action.

**2.9(3)** The commission shall commence a rule-making proceeding within 60 days of its receipt of a petition for rule making seeking the amendment or repeal of a rule that differs from the proposed rule contained in the Notice of Intended Action on which the rule is based, unless the commission finds that the differences between the adopted rule and the proposed rule are so insubstantial as to make such a rule-making proceeding unnecessary. A copy of any such finding and the petition to which it

responds shall be sent to petitioner, the administrative rules coordinator, and the administrative rules review committee within three days of its issuance.

**2.9(4)** Concurrent rule-making proceedings. Nothing in this rule disturbs the discretion of the commission to initiate, concurrently, several different rule-making proceedings on the same subject with several different published Notices of Intended Action.

**283—2.10(17A) Exemptions from public rule-making procedures.**

**2.10(1)** *Omission of notice and comment.* To the extent the commission finds that public notice and participation are unnecessary, impracticable, or contrary to the public interest in the process of adopting a particular rule, the commission may adopt that rule without publishing advance Notice of Intended Action in the Iowa Administrative Bulletin and without providing for written or oral public submissions prior to its adoption. The commission shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

**2.10(2)** *Public proceedings on rules adopted without them.* The commission may, at any time, commence a standard rule-making proceeding for the adoption of a rule that is identical or similar to a rule it adopts in reliance upon subrule 2.10(1). Upon written petition by a governmental subdivision, the administrative rules review committee, an agency, the administrative rules coordinator, an association having not less than 25 members, or at least 25 persons, the commission shall commence a standard rule-making proceeding for any rule specified in the petition that was adopted in reliance upon subrule 2.10(1). Such a petition must be filed within one year of the publication of the specified rule in the Iowa Administrative Bulletin as an adopted rule. The rule-making proceeding on that rule must be commenced within 60 days of the receipt of such a petition. After a standard rule-making proceeding commenced pursuant to this subrule, the commission may either readopt the rule it adopted without benefit of all usual procedures on the basis of subrule 2.10(1), or may take any other lawful action, including the amendment or repeal of the rule in question, with whatever further proceedings are appropriate.

**283—2.11(17A) Concise statement of reasons.**

**2.11(1)** *General.* When requested by a person, either prior to the adoption of a rule or within 30 days after its publication in the Iowa Administrative Bulletin as an adopted rule, the commission shall issue a concise statement of reasons for the rule. Requests for such a statement must be in writing and be delivered to College Student Aid Commission, 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608. The request should indicate whether the statement is sought for all or only a specified part of the rule. Requests will be considered made on the date received.

**2.11(2)** *Contents.* The concise statement of reasons shall contain:

- a. The reasons for adopting the rule;
- b. An indication of any change between the text of the proposed rule contained in the published Notice of Intended Action and the text of the rule as finally adopted, with the reasons for any such change;
- c. The principal reasons urged in the rule-making proceeding for and against the rule, and the commission's reasons for overruling the arguments made against the rule.

**2.11(3)** *Time of issuance.* After a proper request, the commission shall issue a concise statement of reasons by the later of the time the rule is adopted or 35 days after receipt of the request.

[ARC 1490C, IAB 6/11/14, effective 7/30/14; Editorial change: IAC Supplement 2/10/21]

**283—2.12(17A) Contents, style, and form of rule.**

**2.12(1)** *Contents.* Each rule adopted by the commission shall contain the text of the rule and, in addition:

- a. The date the commission adopted the rule;
- b. A brief explanation of the principal reasons for the rule-making action if such reasons are required by Iowa Code section 17A.4(1b), or the commission in its discretion decides to include such reasons;
- c. A reference to all rules repealed, amended, or suspended by the rule;

- d. A reference to the specific statutory or other authority authorizing adoption of the rule;
- e. Any findings required by any provision of law as a prerequisite to adoption or effectiveness of the rule;
- f. A brief explanation of the principal reasons for the failure to provide for waivers to the rule if no waiver provision is included and a brief explanation of any waiver or special exceptions provided in the rule if such reasons are required by Iowa Code section 17A.4(1b), or the commission in its discretion decides to include such reasons; and
- g. The effective date of the rule.

**2.12(2) *Incorporation by reference.*** The commission may incorporate by reference in a proposed or adopted rule, and without causing publication of the incorporated matter in full, all or any part of a code, standard, rule, or other matter if the commission finds that the incorporation of its text in the commission proposed or adopted rule would be unduly cumbersome, expensive, or otherwise inexpedient. The reference in the commission proposed or adopted rule shall fully and precisely identify the incorporated matter by location, title, citation, date, and edition, if any; shall briefly indicate the precise subject and the general contents of the incorporated matter; and shall state that the proposed or adopted rule does not include any later amendments or editions of the incorporated matter. The commission may incorporate such matter by reference in a proposed or adopted rule only if the commission makes copies of it readily available to the public. The rule shall state how and where copies of the incorporated matter may be obtained at cost from the commission, and how and where copies may be obtained from the agency of the United States, this state, another state, or the organization, association, or persons, originally issuing that matter. The commission shall retain permanently a copy of any materials incorporated by reference in a rule of the commission.

If the commission adopts standards by reference to another publication, it shall provide a copy of the publication containing the standards to the administrative rules coordinator for deposit in the state law library and may make the standards available electronically.

**2.12(3) *References to materials not published in full.*** When the administrative code editor decides to omit the full text of a proposed or adopted rule because publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient, the commission shall prepare and submit to the administrative code editor for inclusion in the Iowa Administrative Bulletin and Iowa Administrative Code a summary statement describing the specific subject matter of the omitted material. This summary statement shall include the title and a brief description sufficient to inform the public of the specific nature and subject matter of the proposed or adopted rules, and of significant issues involved in these rules. The summary statement also shall describe how a copy of the full text of the proposed or adopted rule, including any unpublished matter and any matter incorporated by reference, may be obtained from the commission. The commission will provide a copy of that full text at actual cost upon request and shall make copies of the full text available for review at the state law library and may make the standards available electronically.

At the request of the administrative code editor, the commission shall provide a proposed statement explaining why publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient.

**2.12(4) *Style and form.*** In preparing its rules, the commission shall follow the uniform numbering system, form, and style prescribed by the administrative rules coordinator.

### **283—2.13(17A) Agency rule-making record.**

**2.13(1) *Requirement.*** The commission shall maintain an official rule-making record for each rule it proposes by publication in the Iowa Administrative Bulletin of a Notice of Intended Action, or adopts. The rule-making record and materials incorporated by reference must be available for public inspection.

**2.13(2) *Contents.*** The commission rule-making record shall contain:

- a. Copies of all publications in the Iowa Administrative Bulletin with respect to the rule or the proceeding upon which the rule is based and any file-stamped copies of commission submissions to the administrative rules coordinator concerning that rule or the proceeding upon which it is based;

b. Copies of any portions of the commission's public rule-making docket containing entries relating to the rule or the proceeding upon which the rule is based;

c. All written petitions, requests, and submissions received by the commission, and all other written materials of a factual nature as distinguished from opinion that are relevant to the merits of the rule and that were created or compiled by the commission and considered by the executive director, in connection with the formulation, proposal, or adoption of the rule or the proceeding upon which the rule is based, except to the extent the commission is authorized by law to keep them confidential; provided, however, that when any such materials are deleted because they are authorized by law to be kept confidential, the commission shall identify in the record the particular materials deleted and state the reasons for that deletion;

d. Any official transcript of oral presentations made in the proceeding upon which the rule is based or, if not transcribed, the stenographic record or electronic recording of those presentations, and any memorandum prepared by a presiding officer summarizing the contents of those presentations;

e. A copy of any regulatory analysis or fiscal impact statement prepared for the proceeding upon which the rule is based;

f. A copy of the rule and any concise statement of reasons prepared for that rule;

g. All petitions for amendments or repeal or suspension of the rule;

h. A copy of any objection to the issuance of that rule without public notice and participation that was filed pursuant to Iowa Code section 17A.4(2) by the administrative rules review committee, the governor, or the attorney general;

i. A copy of any objection to the rule filed by the administrative rules review committee, the governor, or the attorney general pursuant to Iowa Code section 17A.4(4), and any commission response to that objection;

j. A copy of any significant written criticism of the rule, including a separate file of any petitions for waiver of the rule; and

k. A copy of any executive order concerning the rule.

**2.13(3) *Effect of record.*** Except as otherwise required by a provision of law, the commission rule-making record required by this rule need not constitute the exclusive basis for commission action on that rule.

**2.13(4) *Maintenance of files.*** The commission shall maintain the rule-making file for a period of not less than five years from the later of the date the rule to which it pertains became effective, the date of the Notice of Intended Action, or the date of any written criticism as described in 2.13(2) "g," "h," "i," or "j."

**283—2.14(17A) Filing of rules.** The commission shall file each rule it adopts in the office of the administrative rules coordinator. The filing must be executed as soon after adoption of the rule as is practicable. At the time of filing, each rule must have attached to it any fiscal impact statement and any concise statement of reasons that was issued with respect to that rule. If a fiscal impact statement or statement of reasons for that rule was not issued until a time subsequent to the filing of that rule, the note or statement must be attached to the filed rule within five working days after the note or statement is issued. In filing a rule, the commission shall use the standard form prescribed by the administrative rules coordinator.

**283—2.15(17A) Effectiveness of rules prior to publication.**

**2.15(1) *Grounds.*** The commission may make a rule effective after its filing at any stated time prior to 35 days after its indexing and publication in the Iowa Administrative Bulletin if it finds that a statute so provides, the rule confers a benefit or removes a restriction on some segment of the public, or that the effective date of the rule is necessary to avoid imminent peril to the public health, safety, or welfare. The commission shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

**2.15(2) *Special notice.*** When the commission makes a rule effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2) "b"(3), the commission

shall employ all reasonable efforts to make its contents known to the persons who may be affected by that rule prior to the rule's indexing and publication. The term "all reasonable efforts" requires the commission to employ the most effective and prompt means of notice rationally calculated to inform potentially affected parties of the effectiveness of the rule that is justified and practical under the circumstances considering the various alternatives available for this purpose, the comparative costs to the commission of utilizing each of those alternatives, and the harm suffered by affected persons from any lack of notice concerning the contents of the rule prior to its indexing and publication. The means that may be used for providing notice of such rules prior to their indexing and publication include, but are not limited to, any one or more of the following means: radio, newspaper, television, signs, mail, telephone, personal notice or electronic means.

A rule made effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2) "b"(3) shall include in that rule a statement describing the reasonable efforts that will be used to comply with the requirements of subrule 2.15(2).

### **283—2.16(17A) General statements of policy.**

**2.16(1)** *Compilation, indexing, public inspection.* The commission shall maintain an official, current, and dated compilation that is indexed by subject, containing all of its general statements of policy within the scope of Iowa Code section 17A.2(11) "a," "c," "f," "g," "h," "k." Each addition to, change in, or deletion from the official compilation must also be dated, indexed, and a record thereof kept. Except for those portions containing rules governed by Iowa Code section 17A.2(11) "f," or otherwise authorized by law to be kept confidential, the compilation must be made available for public inspection and copying.

**2.16(2)** *Enforcement of requirements.* A general statement of policy subject to the requirements of this subsection shall not be relied on by the commission to the detriment of any person who does not have actual, timely knowledge of the contents of the statement until the requirements of subrule 2.16(1) are satisfied. This provision is inapplicable to the extent necessary to avoid imminent peril to the public health, safety, or welfare.

### **283—2.17(17A) Review by commission of rules.**

**2.17(1)** Any interested person, association, agency, or political subdivision may submit a written request to the administrative rules coordinator requesting the commission to conduct a formal review of a specified rule. Upon approval of that request by the administrative rules coordinator, the commission shall conduct a formal review of a specified rule to determine whether a new rule should be adopted instead or the rule should be amended or repealed. The commission may refuse to conduct a review if it has conducted such a review of the specified rule within five years prior to the filing of the written request.

**2.17(2)** In conducting the formal review, the commission shall prepare within a reasonable time a written report summarizing its findings, its supporting reasons, and any proposed course of action. The report must include a concise statement of the commission's findings regarding the rule's effectiveness in achieving its objectives, including a summary of any available supporting data. The report shall also concisely describe significant written criticisms of the rule received during the previous five years, including a summary of any petitions for waiver of the rule received by the commission or granted by the commission. The report shall describe alternative solutions to resolve the criticisms of the rule, the reasons any were rejected, and any changes made in the rule in response to the criticisms as well as the reasons for the changes. A copy of the commission's report shall be sent to the administrative rules review committee and the administrative rules coordinator. The report must also be available for public inspection.

These rules are intended to implement Iowa Code chapter 17A.

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CHAPTER 3  
DECLARATORY ORDERS

[Prior to 8/10/88, see College Aid Commission, 245—13.4 and 13.5]

**283—3.1(17A) Petition for declaratory order.** Any person may file a petition with the college student aid commission for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the commission, at 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608. A petition is deemed filed when it is received by the commission. The commission shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

COLLEGE STUDENT AID COMMISSION	
Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).	} PETITION FOR DECLARATORY ORDER

The petition must provide the following information:

1. A clear and concise statement of all relevant facts on which the order is requested.
2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner’s interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting provided for by 3.7(17A).

The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner’s representative and a statement indicating the person to whom communications concerning the petition should be directed.

[ARC 1490C, IAB 6/11/14, effective 7/30/14; Editorial change: IAC Supplement 2/10/21]

**283—3.2(17A) Notice of petition.** Within 15 days after receipt of a petition for a declaratory order, the college student aid commission shall give notice of the petition to all persons not served by the petitioner pursuant to 3.6(17A) to whom notice is required by any provision of law. The commission may also give notice to any other persons.

**283—3.3(17A) Intervention.**

**3.3(1)** Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 15 days of the filing of a petition for declaratory order (after time for notice under 3.2(17A) and before 30-day time for agency action under 3.8(17A)) shall be allowed to intervene in a proceeding for a declaratory order.

**3.3(2)** Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the commission.

**3.3(3)** A petition for intervention shall be filed at 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608. Such a petition is deemed filed when it is received by the commission. The commission will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides

an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

COLLEGE STUDENT AID COMMISSION	
Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite provisions of law cited in original petition).	} PETITION FOR INTERVENTION

The petition for intervention must provide the following information:

1. Facts supporting the intervenor's standing and qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
4. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

[ARC 1490C, IAB 6/11/14, effective 7/30/14; Editorial change: IAC Supplement 2/10/21]

**283—3.4(17A) Briefs.** The petitioner or any intervenor may file a brief in support of the position urged. The commission may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

**283—3.5(17A) Inquiries.** Inquiries concerning the status of a declaratory order proceeding may be made to Executive Director, College Student Aid Commission, 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608.

[ARC 1490C, IAB 6/11/14, effective 7/30/14; Editorial change: IAC Supplement 2/10/21]

**283—3.6(17A) Service and filing of petitions and other papers.**

**3.6(1) When service required.** Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

**3.6(2) Filing—when required.** All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the College Student Aid Commission, 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the commission.

**3.6(3) Method of service, time of filing, and proof of mailing.** Method of service, time of filing, and proof of mailing shall be as provided by uniform rule on contested cases 3.12(17A).

[ARC 1490C, IAB 6/11/14, effective 7/30/14; Editorial change: IAC Supplement 2/10/21]

**283—3.7(17A) Consideration.** Upon request by petitioner, the college student aid commission must schedule a brief and informal meeting between the original petitioner, all intervenors, and the commission, a member of the commission, or a member of the staff of the commission, to discuss the questions raised. The commission may solicit comments from any person on the questions raised. Comments on the questions raised may be submitted to the commission by any person.

**283—3.8(17A) Action on petition.**

**3.8(1)** Within the time allowed by Iowa Code section 17A.9(5) after receipt of a petition for a declaratory order, the executive director or designee shall take action on the petition as required by Iowa Code section 17A.9(5).

**3.8(2)** The date of issuance of an order or of a refusal to issue an order is as defined in contested case uniform rule 283—4.2(17A).

**283—3.9(17A) Refusal to issue order.**

**3.9(1)** The commission shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1) and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

1. The petition does not substantially comply with the required form.
2. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the commission to issue an order.
3. The commission does not have jurisdiction over the questions presented in the petition.
4. The questions presented by the petition are also presented in a current rule making, contested case, or other commission or judicial proceeding, that may definitively resolve them.
5. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
6. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
7. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.
8. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge a commission decision already made.
9. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.
10. The petitioner requests the commission to determine whether a statute is unconstitutional on its face.

**3.9(2)** A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final commission action on the petition.

**3.9(3)** Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

**283—3.10(17A) Contents of declaratory order—effective date.** In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

**283—3.11(17A) Copies of orders.** A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

**283—3.12(17A) Effect of a declaratory order.** A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the commission, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was

based. As to all other persons, a declaratory order serves only as precedent and is not binding on the commission. The issuance of a declaratory order constitutes final commission action on the petition.

These rules are intended to implement Iowa Code chapter 17A.

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[Editorial change: IAC Supplement 2/10/21]

CHAPTER 5  
CONTESTED CASES  
[Prior to 10/15/03, see 283—Ch 4]

**283—5.1(17A) Scope and applicability.** This chapter applies to contested case proceedings conducted by the college student aid commission.

**283—5.2(17A) Definitions.** Except where otherwise specifically defined by law:

“*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.

“*Issuance*” means the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

“*Party*” means 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 the executive director.

“*Proposed decision*” means the presiding officer’s recommended findings of fact, conclusions of law, decision, and order in a contested case in which the college student aid commission did not preside.

**283—5.3(17A) Time requirements.**

**5.3(1)** Time shall be computed as provided in Iowa Code section 4.1(34).

**5.3(2)** For good cause, the presiding officer may extend or shorten the time to take any action, except as precluded by statute. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer shall afford all parties an opportunity to be heard or to file written arguments.

**283—5.4(17A) Requests for contested case proceeding.** Any person claiming an entitlement to a contested case proceeding shall file a written request for such a proceeding within the time specified by the particular rules or statutes governing the subject matter or, in the absence of such law, the time specified in the commission action in question.

The request for a contested case proceeding should state the name and address of the requester, identify the specific commission action which is disputed, and, where the requester is represented by a lawyer, identify the provisions of law or precedent requiring or authorizing the holding of a contested case proceeding in the particular circumstances involved, and include a short and plain statement of the issues of material fact in dispute.

**283—5.5(17A) Notice of hearing.**

**5.5(1) Delivery.** Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. Delivery may be executed by:

- a. Personal service as provided in the Iowa Rules of Civil Procedure; or
- b. Certified mail, return receipt requested; or
- c. First-class mail; or
- d. Publication, as provided in the Iowa Rules of Civil Procedure.

**5.5(2) Contents.** The notice of hearing shall contain the following information:

- a. A statement of the time, place, and nature of the hearing;
- b. A statement of the legal authority and jurisdiction under which the hearing is to be held;
- c. A reference to the particular sections of the statutes and rules involved;
- d. A short and plain statement of the matters asserted. If the commission or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application, a more definite and detailed statement shall be furnished;
- e. Identification of all parties including the name, address and telephone number of the person who will act as advocate for the commission or the state and of parties’ counsel where known;
- f. Reference to the procedural rules governing conduct of the contested case proceeding;

- g.* Reference to the procedural rules governing informal settlement;
- h.* Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer (e.g., agency head, members of multimembered agency head, administrative law judge from the department of inspections and appeals); and
- i.* Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11(1) and rule 283—5.6(17A), that the presiding officer be an administrative law judge.

**283—5.6(17A) Presiding officer.**

**5.6(1)** Any party who wishes to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the department of inspections and appeals must file a written request within 20 days or such other time period the commission designates after service of a notice of hearing which identifies or describes the presiding officer as the executive director or members of the commission.

**5.6(2)** The commission or its designee may deny the request only upon a finding that one or more of the following apply:

- a.* Neither the commission nor any officer of the commission under whose authority the contested case is to take place is a named party to the proceeding or a real party in interest to that proceeding.
- b.* There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety, or welfare.
- c.* A qualified administrative law judge is unavailable to hear the case within a reasonable time.
- d.* The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.
- e.* The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.
- f.* Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal.
- g.* The request was not timely filed.
- h.* The request is not consistent with a specified statute.

**5.6(3)** The commission or its designee shall issue a written ruling specifying the grounds for its decision within 20 days or such other time period the commission designates after a request for an administrative law judge is filed. The parties shall be notified at least 10 days prior to hearing if a qualified administrative law judge will not be available.

**5.6(4)** Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the commission. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

**5.6(5)** Unless otherwise provided by law, agency heads and members of multimembered agency heads, when reviewing a proposed decision upon intra-agency appeal, shall have the powers of and shall comply with the provisions of this chapter which apply to presiding officers.

**283—5.7(17A) Waiver of procedures.** Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the commission, in its discretion, may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

**283—5.8(17A) Telephone proceedings.** The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen.

**283—5.9(17A) Disqualification.**

**5.9(1)** A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

- a.* Has a personal bias or prejudice concerning a party or a representative of a party;

b. Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;

c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;

d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;

e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

f. Has a spouse or relative within the third degree of relationship that: (1) is a party to the case, or an officer, director or trustee of a party; (2) is a lawyer in the case; (3) is known to have an interest that could be substantially affected by the outcome of the case; or (4) is likely to be a material witness in the case; or

g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

**5.9(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 commission functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17(3) and subrules 5.9(3) and 5.23(9).

**5.9(3)** In a situation where a presiding officer or other person knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

**5.9(4)** If a party asserts disqualification on any appropriate ground, including those listed in subrule 5.9(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party.

If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 283—5.25(17A) and seek a stay under rule 283—5.29(17A).

#### **283—5.10(17A) Consolidation—severance.**

**5.10(1) Consolidation.** The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where: (a) the matters at issue involve common parties or common questions of fact or law; (b) consolidation would expedite and simplify consideration of the issues involved; and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

**5.10(2) Severance.** The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

#### **283—5.11(17A) Pleadings.**

**5.11(1)** Pleadings may be required by rule, by the notice of hearing, or by order of the presiding officer.

**5.11(2)** Petition.

*a.* Any petition required in a contested case proceeding shall be filed within 20 days of delivery of the notice of hearing or subsequent order of the presiding officer, unless otherwise ordered.

*b.* A petition shall state in separately numbered paragraphs the following:

- (1) The persons or entities on whose behalf the petition is filed;
- (2) The particular provisions of statutes and rules involved;
- (3) The relief demanded and the facts and law relied upon for such relief; and
- (4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

**5.11(3)** Answer. An answer shall be filed within 20 days of service of the petition unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement when appropriate.

An 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 contain as many additional defenses as the pleader may claim.

An answer shall state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

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.

**5.11(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.

**283—5.12(17A) Service and filing of pleadings and other papers.**

**5.12(1)** *When service required.* Except where otherwise provided by law, every pleading, motion, document, or other paper filed in a contested case proceeding and every paper relating to discovery in such a proceeding shall be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the state or the commission, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

**5.12(2)** *Service—how made.* Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

**5.12(3)** *Filing—when required.* After the notice of hearing, all pleadings, motions, documents or other papers in a contested case proceeding shall be filed with the college student aid commission.

**5.12(4)** *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the college student aid commission, delivered to an established courier service for immediate delivery to that office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

**5.12(5)** *Proof of mailing.* Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the College Student Aid Commission, 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608, and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).

(Date) (Signature)  
[ARC 1684C, IAB 10/29/14, effective 12/3/14; Editorial change: IAC Supplement 2/10/21]

**283—5.13(17A) Discovery.**

**5.13(1)** Discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

**5.13(2)** Any motion relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule 5.13(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

**5.13(3)** Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

**283—5.14(17A) Subpoenas.****5.14(1) Issuance.**

*a.* An agency subpoena shall be issued to a party on request. Such a request must be in writing. In the absence of good cause for permitting later action, a request for a subpoena must be received at least three days before the scheduled hearing. The request shall include the name, address, and telephone number of the requesting party.

*b.* Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

**5.14(2)** *Motion to quash or modify.* The presiding officer may quash or modify a subpoena for any lawful reason upon motion in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be set for argument promptly.

**283—5.15(17A) Motions.**

**5.15(1)** No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

**5.15(2)** Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by rules of the commission or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

**5.15(3)** The presiding officer may schedule oral argument on any motion.

**5.15(4)** Motions pertaining to the hearing, except motions for summary judgment, must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the commission or an order of the presiding officer.

**5.15(5)** Motions for summary judgment. Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 1.981 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases.

Motions for summary judgment must be filed and served at least 45 days prior to the scheduled hearing date, or other time period determined by the presiding officer. Any party resisting the motion shall file and serve a resistance within 15 days, unless otherwise ordered by the presiding officer, from the date a copy of the motion was served. The time fixed for hearing or nonoral submission shall be not less than 20 days after the filing of the motion, unless a shorter time is ordered by the presiding officer. A summary judgment order rendered on all issues in a contested case is subject to rehearing pursuant to 283—5.28(17A) and appeal pursuant to 283—5.27(17A).

**283—5.16(17A) Prehearing conference.**

**5.16(1)** Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the executive director to all parties. For good cause the presiding officer may permit variances from this rule.

**5.16(2)** Each party shall bring to the prehearing conference:

*a.* A final list of the witnesses who the party anticipates will testify at 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 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.

*c.* Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

**5.16(3)** In addition to the requirements of subrule 5.16(2), the parties at a prehearing conference may:

*a.* Enter into stipulations of law or fact;

*b.* Enter into stipulations on the admissibility of exhibits;

*c.* Identify matters which the parties intend to request be officially noticed;

*d.* Enter into stipulations for waiver of any provision of law; and

*e.* Consider any additional matters which will expedite the hearing.

**5.16(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.

**283—5.17(17A) Continuances.** Unless otherwise provided, applications for continuances shall be made to the presiding officer.

**5.17(1)** A written application for a continuance shall:

*a.* Be made at the earliest possible time and no less than seven days before the hearing except in case of unanticipated emergencies;

*b.* State the specific reasons for the request; and

*c.* Be signed by the requesting party or the party's representative.

An oral application for a continuance may be made if the presiding officer waives the requirement for a written motion. However, a party making such an oral application for a continuance must confirm that request by written application within five days after the oral request unless that requirement is waived by the presiding officer. No application for continuance shall be made or granted without notice to all parties except in an emergency where notice is not feasible. The commission may waive notice of such requests for a particular case or an entire class of cases.

**5.17(2)** In determining whether to grant a continuance, the presiding officer may consider:

*a.* Prior continuances;

*b.* The interests of all parties;

*c.* The likelihood of informal settlement;

*d.* The existence of an emergency;

*e.* Any objection;

*f.* Any applicable time requirements;

*g.* The existence of a conflict in the schedules of counsel, parties, or witnesses;

*h.* The timeliness of the request; and

*i.* Other relevant factors.

The presiding officer may require documentation of any grounds for continuance.

**283—5.18(17A) Withdrawals.** A party requesting a contested case proceeding may withdraw that request prior to the hearing only in accordance with commission rules. Unless otherwise provided, a withdrawal shall be with prejudice.

**283—5.19(17A) Intervention.**

**5.19(1) Motion.** A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

**5.19(2) When filed.** Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. Unless inequitable or unjust, an intervenor shall be bound by any agreement, arrangement, or other matter previously raised in the case. Requests by untimely intervenors for continuances which would delay the proceeding will ordinarily be denied.

**5.19(3) Grounds for intervention.** The movant shall demonstrate that: (a) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (b) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (c) the interests of the movant are not adequately represented by existing parties.

**5.19(4) Effect of intervention.** If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate actively in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues that may be raised by the intervenor or otherwise condition the intervenor's participation in the proceeding.

**283—5.20(17A) Hearing procedures.**

**5.20(1)** The presiding officer presides at the hearing, and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

**5.20(2)** All objections shall be timely made and stated on the record.

**5.20(3)** Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, or associations may be represented by any member, officer, director, or duly authorized agent. Any party may be represented by an attorney or another person authorized by law.

**5.20(4)** Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

**5.20(5)** The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

**5.20(6)** Witnesses may be sequestered during the hearing.

**5.20(7)** The presiding officer shall conduct the hearing in the following manner:

*a.* The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

*b.* The parties shall be given an opportunity to present opening statements;

*c.* Parties shall present their cases in the sequence determined by the presiding officer;

*d.* Each witness shall be sworn or affirmed by the presiding officer or the court reporter, and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

*e.* When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

**283—5.21(17A) Evidence.**

**5.21(1)** The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

**5.21(2)** Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

**5.21(3)** Evidence in the proceeding shall be confined to the issues as to which the parties received notice prior to the hearing unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If the presiding officer decides to admit evidence on issues outside the scope of the notice over the objection of a party who did not have actual notice of those issues, that party, upon timely request, shall receive a continuance sufficient to amend pleadings and to prepare on the additional issue.

**5.21(4)** The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties.

All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

**5.21(5)** Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

**5.21(6)** Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

**283—5.22(17A) Default.**

**5.22(1)** If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

**5.22(2)** Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

**5.22(3)** Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final commission action unless, within 15 days or other period of time specified by statute or rule after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 283—5.27(17A). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

**5.22(4)** The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

**5.22(5)** Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days or other time specified by the commission to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

**5.22(6)** “Good cause” for purposes of this rule shall have the same meaning as “good cause” for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

**5.22(7)** A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 283—5.25(17A).

**5.22(8)** If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

**5.22(9)** A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues but, unless the defaulting party has appeared, it cannot exceed the relief demanded.

**5.22(10)** A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 283—5.29(17A).

**283—5.23(17A) Ex parte communication.**

**5.23(1)** Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the commission or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 5.9(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

**5.23(2)** Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

**5.23(3)** Written, oral or other forms of communication are “ex parte” if made without notice and opportunity for all parties to participate.

**5.23(4)** To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 283—5.12(17A) and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

**5.23(5)** Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

**5.23(6)** The executive director or other persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under any provision of law and they comply with subrule 5.23(1).

**5.23(7)** 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 pursuant to rule 283—5.17(17A).

**5.23(8)** 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. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written

responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order or 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 the communication.

**5.23(9)** 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.

**5.23(10)** The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the commission. Violation of ex parte communication prohibitions by commission personnel shall be reported to the executive director for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

**283—5.24(17A) Recording costs.** Upon request, the college student aid commission shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

**283—5.25(17A) Interlocutory appeals.** Upon written request of a party or on its own motion, the commission may review an interlocutory order of the executive director. In determining whether to do so, the commission shall weigh the extent to which its granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the commission at the time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

**283—5.26(17A) Final decision.**

**5.26(1)** When the commission presides over the reception of evidence at the hearing, its decision is a final decision.

**5.26(2)** When the commission does not preside at the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the commission without further proceedings unless there is an appeal to, or review on motion of, the commission within the time provided in rule 283—5.27(17A).

**283—5.27(17A) Appeals and review.**

**5.27(1) Appeal by party.** Any adversely affected party may appeal a proposed decision to the commission within 30 days after issuance of the proposed decision.

**5.27(2) Review.** The commission may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

**5.27(3) Notice of appeal.** An appeal of a proposed decision is initiated by filing a timely notice of appeal with the college student aid commission. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

- a. The parties initiating the appeal;
- b. The proposed decision or order appealed from;

c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;

d. The relief sought;

e. The grounds for relief.

**5.27(4) Requests to present additional evidence.** A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The commission may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

**5.27(5) Scheduling.** The college student aid commission shall issue a schedule for consideration of the appeal.

**5.27(6) Briefs and arguments.** Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs. The commission may resolve the appeal on the briefs or provide an opportunity for oral argument. The commission may shorten or extend the briefing period as appropriate.

### **283—5.28(17A) Applications for rehearing.**

**5.28(1) By whom filed.** Any party to a contested case proceeding may file an application for rehearing from a final order.

**5.28(2) Content of application.** The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the commission decision on the existing record and whether, on the basis of the grounds enumerated in subrule 5.27(4), the applicant requests an opportunity to submit additional evidence.

**5.28(3) Time of filing.** The application shall be filed with the college student aid commission within 20 days after issuance of the final decision.

**5.28(4) Notice to other parties.** A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the commission shall serve copies on all parties.

**5.28(5) Disposition.** Any application for a rehearing shall be deemed denied unless the commission grants the application within 20 days after its filing.

### **283—5.29(17A) Stays of commission actions.**

**5.29(1) When available.**

a. Any party to a contested case proceeding may petition the college student aid commission for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the commission. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The commission may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the college student aid commission 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.

**5.29(2) When granted.** In determining whether to grant a stay, the presiding officer or commission shall consider the factors listed in Iowa Code section 17A.19(5c).

**5.29(3) Vacation.** A stay may be vacated by the issuing authority upon application of the college student aid commission or any other party.

**283—5.30(17A) No factual dispute contested cases.** If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties

may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

**283—5.31(17A) Emergency adjudicative proceedings.**

**5.31(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 Constitution and other provisions of law, the commission 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 commission by emergency adjudicative order. Before issuing an emergency adjudicative order, the commission shall consider factors including, but not limited to, the following:

- a. Whether there has been a sufficient factual investigation to ensure that the commission is proceeding on the basis of reliable information;
- b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;
- c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and
- e. Whether the specific action contemplated by the commission is necessary to avoid the immediate danger.

**5.31(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 in the commission'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 utilizing one or more of the following procedures:

- (1) Personal delivery;
- (2) Certified mail, return receipt requested, to the last address on file with the commission;
- (3) Certified mail to the last address on file with the commission;
- (4) First-class mail to the last address on file with the commission; or
- (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 commission orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the commission shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

**5.31(3) *Oral notice.*** Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the commission shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

**5.31(4) *Completion of proceedings.*** After the issuance of an emergency adjudicative order, the commission 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 commission proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further commission proceedings to a later date will be granted only in compelling circumstances upon application in writing.

These rules are intended to implement Iowa Code chapter 17A.

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CHAPTER 6  
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

**283—6.1(17A,22) Definitions.** As used in this chapter:

“*Commission*” means the Iowa college student aid commission.

“*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 records or information contained in records that the commission is prohibited by law from making available for examination by members of the public, and records or information contained in records that are 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.

“*Custodian*” means the commission, or a person lawfully delegated authority by the commission to act for the commission in implementing Iowa Code chapter 22.

“*Open record*” means a record other than a confidential record.

“*Personally identifiable information*” means information about or pertaining to an individual in a record which identifies the individual and which is contained in a record system.

“*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 commission.

“*Record system*” means any group of records under the control of the commission from which a record may be retrieved by a personal identifier such as the name of an individual, number, symbol, or other unique retriever assigned to an individual.

**283—6.2(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 commission determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. The commission is committed to the policies set forth in Iowa Code chapter 22; commission staff shall cooperate with members of the public in implementing the provisions of that chapter.

**283—6.3(17A,22) Requests for access to records.**

**6.3(1) Location of record.** A request for access to a record should be directed to the Executive Director, Iowa College Student Aid Commission, 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608. If a request for access to a record is misdirected, commission personnel will promptly forward the request to the appropriate person.

**6.3(2) Office hours.** Open records shall be made available during all customary office hours, which are 8 a.m. to 4:30 p.m. Monday through Friday, except holidays.

**6.3(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.

**6.3(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 283—6.4(17A,22) and other applicable provisions of law.

**6.3(5) *Security of record.*** No person may, without permission from the custodian, search or remove any record from commission files. Examination and copying of commission records shall be supervised by the custodian or a designee of the custodian. Records shall be protected from damage and disorganization.

**6.3(6) *Copying.*** A reasonable number of copies of an open record may be made in the commission's office. If photocopy equipment is not available in the commission 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.

**6.3(7) *Fees.***

*a. When charged.* The commission 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 commission shall be prominently posted in commission offices. Copies of records may be made by or for members of the public on commission photocopy machines or from electronic storage systems at cost as determined and posted in commission 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 commission expenses in supervising the examination and copying of requested records when the supervision time required is in excess of one hour. The custodian shall prominently post in commission 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 commission 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 the requester.

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**283—6.4(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 283—6.3(17A,22).

**6.4(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.

**6.4(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.

**6.4(3) *Notice to subject of record and opportunity to obtain injunction.*** After the custodian receives a request for access to a confidential record, and before the custodian releases such a record, the custodian may make reasonable efforts to notify promptly any person who is a subject of that record, is identified in that record, and whose address or telephone number is contained in that record. To the extent such a delay is practicable and in the public interest, the custodian may give the subject of such a confidential

record to whom notification is transmitted a reasonable opportunity to seek an injunction under Iowa Code section 22.8, and indicate to the subject of the record the specific period of time during which disclosure will be delayed for that purpose.

**6.4(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.

**6.4(5) *Request granted.*** When the custodian grants a request for access to a confidential record to a particular person, the custodian shall notify that person and indicate any lawful restrictions imposed by the custodian on that person's examination and copying of the record.

**283—6.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination.** 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.

**6.5(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.

**6.5(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. 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. A person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit enumerating the specific reasons justifying the treatment of that record as a confidential record and to provide any proof necessary to establish relevant facts. Requests for treatment of a record as such a confidential record for a limited time period shall also specify the precise period of time for which that treatment is requested.

A person filing such a request shall, if possible, accompany the request with 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 commission by the person requesting such 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.

**6.5(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 commission 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.

**6.5(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.

**6.5(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.

**6.5(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 the 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.

**283—6.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records.** Except as otherwise provided by law, a person 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 person. However, this does not authorize a person who is a subject of such a record to alter the original copy of that record or to expand the official record of any commission proceeding. The requester shall send the request to review such a record or the written statement of additions, dissents, or objections to the custodian or to the Iowa college student aid commission. The request to review such a record or the written statement of such a record of additions, dissents, or objections must be dated and signed by the requester, and shall include the current address and telephone number of the requester or the requester's representative.

**283—6.7(17A,22) Consent to disclosure by the subject of a confidential record.** To the extent permitted by any applicable provision of law, a person who is 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 that may be disclosed, and the particular person or class of persons to whom the record may be disclosed (and, where applicable, the time period during which the record may be disclosed). The person who is 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. (Additional requirements may be necessary for special classes of records.) Appearance of counsel before the commission on behalf of a person who is the subject of a confidential record is deemed to constitute consent for the commission to disclose records about that person to the person's attorney.

**283—6.8(17A,22) Notice to suppliers of information.** When the commission requests a person to supply information about that person, the commission shall notify the person of the use that will be made of the information, which persons outside the commission 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. 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.

**283—6.9(17A,22) Routine use.**

**6.9(1) Defined.** "Routine use" means the disclosure of a record without the consent of the subject or subjects, for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required to be made by statute other than the public records law, Iowa Code chapter 22.

**6.9(2)** To the extent allowed by law, the following are considered routine uses of all commission records:

*a.* Disclosure of officers, employees, and agents of the commission who have a need for the record in the performance of their duties. The custodian of the record may, upon request of an officer or employee, or on the custodian's own initiative, determine what constitutes legitimate need to use confidential records.

*b.* Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible prosecution, civil court action, or regulatory order.

*c.* Disclosure to the department of inspections and appeals regarding matters in which it performs services or functions on behalf of the commission.

*d.* Transfers of information within the commission, to other state agencies, or to local units of government, as appropriate, to administer the program for which the information is collected.

*e.* Information released to staff of federal and state entities for audit purposes or to determine whether the commission is lawfully operating a program.

*f.* Any disclosure specifically authorized by the statute under which the record is collected or maintained.

**283—6.10(17A,22) Consensual disclosure of confidential records.**

**6.10(1)** *Consent to disclosure by a subject.* The subject may consent in writing to commission disclosure of confidential records as provided in rule 283—6.7(17A,22).

**6.10(2)** *Complaints to public officials.* A letter from a subject of a confidential record to a public official which seeks the official's intervention on behalf of the subject in a matter that involves the commission may be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

**283—6.11(17A,22) Release to subject.** The subject of a confidential record may file a written request to review the subject's confidential records. However, the commission need not release the following records to the subject:

1. The identity of a person providing information to the commission when the information is authorized as confidential pursuant to Iowa Code subsection 22.7(18).
2. The work product of an attorney or otherwise privileged information.
3. Peace officers' investigative reports, except as required by Iowa Code subsection 22.7(5).
4. Those otherwise authorized by law.

**283—6.12(17A,22) Availability of records.** This rule lists the commission records which are open to the public, those which are confidential, and those which are partially open and partially confidential.

Commission records are listed by category, according to the legal basis for confidential treatment (if any). The commission administers federally funded programs, as well as state programs, and is authorized by Iowa Code section 22.9 to enforce confidentiality standards for federal law and regulations as are required for receipt of the funds. A single record may contain information from several categories.

The chart indicates whether the record contains 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:

Code	Meaning	Code	Meaning
O	The records are open for public inspection.	O/C	The record is partially open and partially confidential.
C	The records are confidential and are not open to public inspection.	O/E	The record is partially open to the public and partially exempt from disclosure.
E	The record is exempt from mandatory disclosure to members of the public.	O/E/C	The record is partially open to the public, partially exempt from disclosure, and partially confidential and not open to the public.
E/C	The record is exempt from mandatory disclosure to the public and is confidential and not open to public inspection.	NA	Not applicable.

DESCRIPTION OF RECORD	TYPE OF RECORD	LEGAL AUTHORITY FOR CONFIDENTIALITY	PERSONALLY IDENTIFIABLE INFORMATION	
			LEGAL AUTHORITY FOR INFORMATION	LEGAL AUTHORITY FOR INFORMATION
Records of Commission, Advisory Council, and Committees	O/E	Iowa Code 21.5	No	NA
Rule Making	O	NA	No	NA
Declaratory Ruling Records	O/C	Iowa Code 22.7	No	NA
Rules and Policy Manuals	O	NA	No	NA
General Correspondence	O/E/C	Iowa Code 22.7	Yes	NA
Publications <ul style="list-style-type: none"> <li>• General</li> <li>• GSL</li> <li>• Scholarship</li> </ul>	O	NA	No	NA
Statistical Reports	O	NA	No	NA
Staff Reports	O	NA	No	NA
Financial & Administrative Records	O/E/C	Iowa Code 22.7	Yes	NA
Registration and Approval Records	O	NA	No	NA
Contracts and Interagency Agreements	O/C	Iowa Code 22.7(3)	No	NA
Sealed Bids Prior to Public Opening	C	Iowa Code 22.3, 22.7 and 72.3	No	NA
Appeal Records	O/C	Iowa Code 22.7	Yes	NA
Litigation Files	O/E/C	Iowa Code 22.7	Yes	NA
Privileged Communication and Products of Attorneys Representing the Commission	E/C	Iowa Code 22.7, Iowa Code of Professional Responsibility for Lawyers, Canon 4	No	NA
Individual Applicant/Recipient Records (such as those collected under the Iowa Tuition Grant and Iowa Vocational-Technical Tuition Grant Programs)	C	Iowa Code 22.7	Yes	P.L. 89-329
Collections	C	Iowa Code 22.7	Yes	Sec. 428[b-c] and Sec. 488[c]
State and Federal Program Records (such as those maintained under the Iowa Tuition Grant Program and the John R. Justice Student Loan Repayment Program)	O	NA	No	NA

[ARC 1869C, IAB 2/18/15, effective 3/25/15]

These rules are intended to implement Iowa Code section 261.3.

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[Editorial change: IAC Supplement 2/10/21]

CHAPTER 7  
UNIFORM RULES FOR WAIVERS

**283—7.1(261,ExecOrd11,17A) Waiver process.** This chapter outlines a uniform process for granting waivers from rules adopted by the commission.

**7.1(1) *Commission authority.*** A waiver from rules adopted by the commission may be granted in accordance with this chapter if:

*a.* The commission has exclusive rule-making authority to promulgate the rule from which a waiver is requested or has final decision-making authority over a contested case in which a waiver is requested; and

*b.* No statute or rule otherwise controls the granting of a waiver from the rule for which a waiver is requested.

**7.1(2) *Interpretive rules.*** These uniform waiver rules shall not apply to rules defining a statute or other provisions of law or precedent if the commission does not have delegated authority to bind the courts with its definition.

**7.1(3) *Compliance with statute.*** No waiver shall be granted from a requirement that is imposed by statute. Any waiver must be consistent with statute.

**283—7.2(261,ExecOrd11,17A) Definition.** For purposes of this chapter, a waiver means action by the commission which suspends in whole or in part the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

**283—7.3(261,ExecOrd11,17A) Scope of chapter.** This chapter outlines generally applicable standards and a uniform process for the granting of individual waivers from rules adopted by the commission in situations where no other more specific applicable law provides for waivers. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede this chapter with respect to any waiver from that rule.

**283—7.4(261,ExecOrd11,17A) Applicability of chapter.** The commission may grant a waiver from a rule only if the commission has jurisdiction over the rule and the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law. The commission may not waive requirements created or duties imposed by statute.

**283—7.5(261,ExecOrd11,17A) Criteria for waiver.** The commission may issue an order, in response to a completed petition or on its own motion, granting a waiver from a rule adopted by the commission, in whole or in part, as applied to the circumstances of a specified person if the commission finds, based on clear and convincing evidence, that:

**7.5(1)** Application of the rule would impose an undue hardship or injustice on the person for whom the waiver is requested; and

**7.5(2)** A waiver of the rule on the basis of the particular circumstances relative to that specified person would be consistent with the public interest; and

**7.5(3)** A waiver of the rule in the specific case would not prejudice the substantial legal rights of any person.

**283—7.6(261,ExecOrd11,17A) Mandatory waivers.** In response to the timely filing of a completed petition requesting a waiver, the commission shall grant a waiver from a rule, in whole or in part, as applied to the particular circumstances of a specified person, if the commission finds that the application of all or a portion of the circumstances of that specified person would not, to any extent, advance or serve any of the purposes of the rule.

**283—7.7(261,ExecOrd11,17A) Burden of persuasion.** The petitioner shall assume the burden of persuasion to demonstrate clear and convincing evidence when a petition is filed for a waiver from a commission rule.

**283—7.8(261,ExecOrd11,17A) Special waiver rule not precluded.** This uniform waiver rule shall not preclude the commission from granting waivers in other contexts or on the basis of other standards if a statute or other commission rule authorizes the commission to do so and the commission deems it appropriate to do so.

**283—7.9(261,ExecOrd11,17A) Administrative deadlines.** When the rule from which a waiver is sought establishes administrative deadlines, the commission shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all persons participating in a particular program offered by the commission.

**283—7.10(261,ExecOrd11,17A) Filing of petition.** A petition for a waiver must be submitted in writing to the commission's Executive Director, 475 S.W. Fifth Street, Suite D, Des Moines, Iowa 50309-4608. [ARC 1869C, IAB 2/18/15, effective 3/25/15; Editorial change: IAC Supplement 2/10/21]

**283—7.11(261,ExecOrd11,17A) Contested case.** If the petition relates to a pending contested case, the petition shall be filed in the contested case proceeding, using the caption of the contested case.

**283—7.12(261,ExecOrd11,17A) Contents of petition.** A petition for waiver shall include the following information where applicable and known to the petitioner:

**7.12(1)** The name, address, telephone number, and social security number of the person or entity for whom a waiver is being requested and the case number of any related contested case, whether pending or closed.

**7.12(2)** A description and citation of the specific rule from which a waiver is requested.

**7.12(3)** The specific waiver requested, including the precise scope and duration.

**7.12(4)** The relevant facts that the petitioner believes would justify a waiver. This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition and a statement of reasons that the petitioner believes will justify a waiver.

**7.12(5)** A history of any prior contacts between the commission and the petitioner. The historical summary shall include:

*a.* A list of all of the programs, contracts, allocations, bond issues, loans, grants, or other activities in which the petitioner has participated or from which the petitioner has received a benefit and which are affected by the proposed waiver.

*b.* A description of each instance when the petitioner has participated in or benefited from any of the commission's programs or contracts, including but not limited to allocations, grants, or loans held by the petitioner, any notices of noncompliance, other administrative events, whether federal or state, contested case hearings, or investigative reports relating to the program, allocation, grant, or loan.

**7.12(6)** Any information known to the petitioner about the commission's treatment of similar cases.

**7.12(7)** The name, address, and telephone number of any person or entity, inside or outside state government, who would be adversely affected by the granting of a petition.

**7.12(8)** The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

**7.12(9)** Signed releases of information authorizing persons with knowledge regarding the request to furnish the commission with information pertaining to the waiver.

**283—7.13(261,ExecOrd11,17A) Additional information.** If the petition for waiver is not filed in a contested case and prior to issuing an order granting or denying a waiver, the executive director may request additional information from the petitioner relative to the petition and circumstances relating to the request for waiver. The request may be in the form of written questions or oral interview. The executive director may interview or direct written questions to other persons in connection with the waiver requested. If the petition was not filed in a contested case, the commission, or its executive director, may, on its own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the commission's executive director, a committee of the commission's staff, or a quorum or committee of the commission's board to consider the petition for waiver.

**283—7.14(261,ExecOrd11,17A) Notice.** The commission shall acknowledge a petition upon receipt. The commission shall ensure that notice of the pendency of the petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law within 30 days of the receipt of the petition. In addition, the commission may give notice to other persons. To accomplish this notice provision, the commission may require the petitioner to serve the notice on all persons to whom notice is required and provide a written statement that notice has been provided.

**283—7.15(261,ExecOrd11,17A) Hearing procedures.** The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply to any petition for a waiver filed within a contested case, and shall otherwise apply to commission proceedings for a waiver of a rule only when the commission so provides by rule or order or is required by statute to do so.

**283—7.16(261,ExecOrd11,17A) Ruling.** An order granting or denying a waiver shall be in writing and shall contain a reference to that particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and operative period of the waiver if one is issued.

**283—7.17(261,ExecOrd11,17A) Commission discretion.** The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the commission, upon consideration of all relevant factors. Each petition for a waiver shall be evaluated by the commission based on the unique, individual circumstances set out in the petition.

**283—7.18(261,ExecOrd11,17A) Narrowly tailored exception.** A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

**283—7.19(261,ExecOrd11,17A) Conditions.** The commission may condition the granting of a waiver on such reasonable conditions as appropriate to achieve the objectives of the particular rule in question through alternative means.

**283—7.20(261,ExecOrd11,17A) Time period of waiver.** A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the commission, a waiver may be renewed if the commission finds that grounds for a waiver continue to exist.

**283—7.21(261,ExecOrd11,17A) Timing for ruling.** The commission shall grant or deny a petition for a waiver as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees to a later date. However, if a petition is filed in a contested case proceeding, the commission shall grant or deny the petition no later than the time at which the final decision in the contested case is issued.

**283—7.22(261,ExecOrd11,17A) When deemed denied.** Failure of the commission to grant or deny a petition within the required time period shall be deemed a denial of that petition by the commission. However, the commission shall remain responsible for issuing an order denying a waiver.

**283—7.23(261,ExecOrd11,17A) Service of order.** Within seven days of its issuance, any order issued under these uniform rules shall be transmitted to the petitioner or the person to whom the order pertains and to any other person entitled to such notice by any provision of law.

**283—7.24(261,ExecOrd11,17A) Public availability.** Subject to the provisions of Iowa Code section 17A.3(1)“e,” the commission shall maintain a record of all orders granting and denying waivers under these uniform rules. All records pertaining to waivers shall be indexed and available to members of the public at the commission’s office. Some petitions may contain information the commission is authorized

or required to keep confidential. The commission may accordingly edit confidential information from petitions or orders prior to public inspection.

**283—7.25(261,ExecOrd11,17A) Voiding or cancellation.** A waiver is void if the material facts upon which the request is based are not true or if material facts have been withheld. The commission may, at any time, cancel a waiver upon appropriate notice and hearing if the commission finds that the facts as stated in the petition are not true, material facts have been withheld, the alternative means of compliance provided in the waiver have failed to achieve the objectives of the statute or rule, or the petitioner has failed to comply with the conditions of the order.

**283—7.26(261,ExecOrd11,17A) Violations.** Violation of conditions in a waiver shall be treated as a violation of the particular rule for which the waiver is granted and is subject to the same remedies or penalties.

**283—7.27(261,ExecOrd11,17A) Defense.** After the commission issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked. The order is not assignable, and it shall not inure to the benefit of the heirs or successors in interest of the person first obtaining the waiver.

**283—7.28(261,ExecOrd11,17A) Judicial review.** Judicial review of a commission decision to grant or deny a waiver petition may be taken in accordance with Iowa Code chapter 17A.

These rules are intended to implement Iowa Code chapter 17A and Executive Order Number 11.

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## **HUMAN SERVICES DEPARTMENT[441]**

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/11/87.

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CHAPTER 9  
PUBLIC RECORDS AND FAIR  
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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 ombudsman 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—98.116(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.

[ARC 5417C, IAB 2/10/21, effective 4/1/21]

**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

DESCRIPTION OF RECORD	TYPE OF RECORD	LEGAL AUTHORITY FOR CONFIDENTIALITY	PERSONALLY IDENTIFIABLE INFORMATION	LEGAL AUTHORITY FOR PI INFORMATION
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
• 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:				

DESCRIPTION OF RECORD	TYPE OF RECORD	LEGAL AUTHORITY FOR CONFIDENTIALITY	PERSONALLY IDENTIFIABLE INFORMATION	LEGAL AUTHORITY FOR PI INFORMATION
• 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
• 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
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 hawki clients
Public Information Exchange	Data exchange between states
PJCASE	Iowa workforce development interface with PROMISE JOBS

<u>System</u>	<u>Function</u>
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
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.

[ARC 5305C, IAB 12/2/20, effective 2/1/21]

**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 [dhs.iowa.gov/appeals](https://dhs.iowa.gov/appeals).

**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.

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CHAPTER 77  
CONDITIONS OF PARTICIPATION FOR PROVIDERS  
OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]

[Prior to 2/11/87, Human Services[498]]

**441—77.1(249A) Physicians.** All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

**441—77.2(249A) Retail pharmacies.** Retail pharmacies are eligible to participate if they meet the requirements of this rule.

**77.2(1) *Licensure.*** Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

**77.2(2) *Survey participation.*** As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

*a.* A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

*b.* A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

*c.* Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs shall be held confidential.

[ARC 0485C, IAB 12/12/12, effective 2/1/13]

**441—77.3(249A) Hospitals.**

**77.3(1) *Qualifications.*** All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

**77.3(2) *Referral to health home services provider.*** As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

**77.3(3) *Psychiatric bed tracking system.*** As a condition of participation in the medical assistance program, hospitals must establish procedures for participating in and updating the statewide psychiatric bed tracking system.

*a.* Definitions.

“*Adult beds*” means the number of staffed and available psychiatric beds ready for admission to individuals 18 years of age to 60 years of age.

“*Child beds*” means the number of staffed and available psychiatric beds ready for admission to individuals up to the age of 18.

“*Gender*” means female or male.

“*Geriatric beds*” means the number of staffed and available psychiatric beds ready for admission to individuals 60 years of age and older.

“*Hospital*,” for purposes of this subrule, means any licensed hospital providing inpatient psychiatric services and the state mental health institutes.

“*Psychiatric bed tracking system*” means a web-based electronic system managed by the department that can be searched to locate inpatient psychiatric services at an Iowa hospital.

- b. Hospitals are required to participate in the psychiatric bed tracking system.
- c. Hospitals shall update the psychiatric bed tracking system, at a minimum, two times per day. The first update shall be entered between 12:00:01 a.m. and 9:59:59 a.m. each day; the second update shall be entered between 8:00:00 p.m. and 11:59:59 p.m. each day.
- d. Each update must include the number of child beds by gender, the number of adult beds by gender, and the number of geriatric beds by gender.
- e. Failure to comply with the psychiatric bed tracking reporting may result in sanctions in accordance with rule 441—79.2(249A).

This rule is intended to implement Iowa Code section 249A.4.  
 [ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 3789C, IAB 5/9/18, effective 7/1/18]

**441—77.4(249A) Dentists.** All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

**441—77.5(249A) Podiatrists.** All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

**441—77.6(249A) Optometrists.** All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

**441—77.7(249A) Opticians.** All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

**441—77.8(249A) Chiropractors.** All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

**441—77.9(249A) Home health agencies.** Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

**77.9(1) Definitions.**

“*Assets*” includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

“*Rider*” means a notice issued by a surety that a change in the bond has occurred or will occur.

“*Uncollected overpayment*” means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

**77.9(2) Parties to surety bonds.** The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety’s name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

**77.9(3) Surety company obligations.** The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

**77.9(4) Surety bond requirements.** Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. *Effective dates and submission dates.*

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. *Amount of bond.* Bonds for any period shall be in the amount of \$50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of \$50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. *Other requirements.* Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability

under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

**77.9(5) Exemption from surety bond requirements for government-operated home health agencies.** A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

**77.9(6) Government-operated home health agency that loses its exemption.** A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

**441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies.** All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

**441—77.11(249A) Ambulance service.** Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

**441—77.12(249A) Behavioral health intervention.** A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or
6. Iowa Administrative Code 441—Chapter 24, “Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities.”

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.13(249A) Hearing aid dispensers.** Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.14(249A) Audiologists.** Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.15(249A) Community mental health centers.** Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.16(249A) Screening centers.** Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health’s standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.17(249A) Physical therapists.** Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.18(249A) Orthopedic shoe dealers and repair shops.** Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.19(249A) Rehabilitation agencies.** Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

This rule is intended to implement Iowa Code section 249A.4.

**441—77.20(249A) Independent laboratories.** Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.21(249A) Rural health clinics.** Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

**441—77.22(249A) Psychologists.**

**77.22(1)** All psychologists licensed to practice in the state of Iowa and meeting the current credentialing requirements of the National Register of Health Service Psychologists are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the current credentialing requirements of the National Register of Health Service Psychologists.

**77.22(2)** A psychologist provisionally licensed to practice in the state of Iowa pursuant to Iowa Code section 154B.6 is eligible to participate in the medical assistance program when the person:

*a.* Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

*b.* Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist.

**77.22(3)** A psychologist provisionally licensed in another state is eligible to participate when the person:

*a.* Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

*b.* Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist who is duly licensed to practice in that state.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.  
[ARC 2165C, IAB 9/30/15, effective 12/1/15; ARC 4165C, IAB 12/5/18, effective 1/9/19]

**441—77.23(249A) Maternal health centers.** A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.24(249A) Ambulatory surgical centers.** Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

**441—77.25(249A) Home- and community-based habilitation services.** To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements in subrules 77.25(2), 77.25(3), 77.25(4), and 77.25(5) and shall meet the requirements in the subrules applicable to the individual services being provided.

**77.25(1) Definitions.**

“Guardian” means a guardian appointed in probate or juvenile court.

“*Major incident*” means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

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

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

“*Minor incident*” means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

“*Provider-owned or controlled setting*” means a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member. The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law.

**77.25(2) Organization and staff.**

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

**77.25(3) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

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

*b. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member's supervisor.
2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

*c. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.25(4) Restraint, restriction, and behavioral intervention.** The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

*a.* The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

*b.* Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

*c.* Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

*d.* Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

*e.* Corporal punishment and verbal or physical abuse are prohibited.

**77.25(5) Residential and nonresidential settings.** Effective March 17, 2022, all home- and community-based services (HCBS), whether residential or nonresidential, shall be provided in integrated, community-based settings that support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Settings shall optimize individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

*a.* Nursing facilities, institutions for mental diseases, intermediate care facilities for persons with an intellectual disability, and hospitals are not considered integrated, community-based settings.

*b.* Any HCBS setting that is located in a building that is also a publicly or privately operated facility, identified in paragraph 77.25(5) “*a*,” that provides inpatient treatment or in a building on the grounds of, or immediately adjacent to, a public institution, identified in paragraph 77.25(5) “*a*,” or any setting that has the effect of isolating members receiving Medicaid HCBS from the broader community will be presumed to be a setting that has the qualities of an institution unless the department conducts a site-specific review and determines otherwise.

*c.* Residential services may be provided in provider-owned or controlled settings. In provider-owned or controlled residential settings:

(1) The member selects the setting from among setting options, including non-disability-specific settings and an option for a private unit in a residential setting.

(2) The setting options are identified and documented in the person-centered service plan and are based on the member’s needs, preferences, and resources available for room and board.

(3) Members have choices regarding services and supports received and who provides them.

(4) Members are assured the rights of privacy, dignity, respect, and freedom from coercion and undue restraint.

(5) Services and supports shall optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

(6) Each member shall be afforded privacy in the member’s sleeping and living unit. Living unit entrance doors and bedroom doors may be locked by the member, and only appropriate staff shall have keys. Staff access to keys must be identified in the member’s person-centered plan.

(7) Members shall have a choice of roommates in that setting.

(8) Members shall have the freedom to furnish and decorate their sleeping or living areas as desired as permitted by any operative lease or other agreement.

(9) Members shall have the freedom and support to control their own schedules and activities and shall have access to food at any time.

(10) Members may have visitors of their choosing at any time.

(11) The setting shall be physically accessible to the member.

**77.25(6) Case management.** A provider is eligible to participate in the home- and community-based habilitation services program as a provider of case management services if accredited as a case management provider pursuant to 441—Chapter 24.

**77.25(7) Day habilitation.**

*a.* The following providers may provide day habilitation:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

(2) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency’s last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.25(7) “*a*”(1), 77.25(7) “*a*”(4), or 77.25(7) “*a*”(7).

(3) An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

(6) An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

(7) An agency that is accredited by the International Center for Clubhouse Development.

(8) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

*b.* Direct support staff providing day habilitation services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within six months of hire or within six months of February 1, 2021, complete at least 9.5 hours of training in supporting members in the activities listed in 701—paragraph 78.27(8)“*a*,” as offered through DirectCourse or Relias or other nationally recognized training curriculum.

(4) A person providing direct support shall annually complete 4 hours of continuing education in supporting members in the activities listed in 701—paragraph 78.27(8)“*a*,” as offered through DirectCourse or Relias or other nationally recognized training curriculum.

**77.25(8) Home-based habilitation.** The following agencies may provide home-based habilitation services:

*a.* An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

*b.* An agency that is accredited under 441—Chapter 24 to provide supported community living services.

*c.* An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

*d.* An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

*e.* An agency that is accredited by the Council on Accreditation of Services for Families and Children.

*f.* An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

**77.25(9) Prevocational habilitation.**

*a.* The following providers may provide prevocational services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(2) An agency that is accredited by the Council on Quality and Leadership.

(3) An agency that is accredited by the International Center for Clubhouse Development.

(4) An agency that is certified by the department to provide prevocational services under:

1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.

(4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

**77.25(10) Supported employment habilitation.**

a. The following agencies may provide supported employment services:

(1) An agency that is certified by the department to provide supported employment services under:

1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

(2) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(3) An agency that is accredited by the Council on Accreditation.

(4) An agency that is accredited by the Joint Commission.

(5) An agency that is accredited by the Council on Quality and Leadership.

(6) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

- (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
- (2) Member vacation, sick leave and holiday compensation.
- (3) Procedures for payment schedules and pay scale.
- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through

DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5307C, IAB 12/2/20, effective 2/1/21]

**441—77.26(249A) Behavioral health services.** The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

**77.26(1) Licensed marital and family therapists (LMFT).** Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

**77.26(2) Temporarily licensed marital and family therapists.** Any person who holds a temporary license to practice marital and family therapy pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed marital and family therapist provides treatment under the supervision of a qualified marital and family therapist as determined by the board of behavioral science by rule. Claims for payment for such services must be submitted by the supervising licensed marital and family therapist.

**77.26(3) Licensed independent social workers (LISW).** Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

**77.26(4) Licensed master social workers (LMSW).**

*a.* A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

- (1) Holds a master's or doctoral degree as approved by the board of social work; and
- (2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

*b.* A master social worker in another state is eligible to participate when the person:

- (1) Is duly licensed to practice in that state; and
- (2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

**77.26(5) Licensed mental health counselors (LMC).** Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

**77.26(6) Temporarily licensed mental health counselors.** Any person temporarily licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed mental health counselor provides treatment under the supervision of a qualified mental health counselor as determined by the board of behavioral science by rule. Claims for payment for such services must be submitted by the supervising licensed mental health counselor.

**77.26(7) Certified alcohol and drug counselors.** Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

**77.26(8) Licensed behavior analysts.** Any person licensed by the board of behavioral science as a behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate. A licensed behavior analyst in another state is eligible to participate when duly licensed to practice in that state.

**77.26(9) Licensed assistant behavior analysts.** A person licensed by the board of behavioral science as an assistant behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate when the licensed assistant behavior analyst:

- a. Holds current certification as an assistant behavior analyst by a certifying entity; and
- b. Provides treatment under the supervision of a behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

This rule is intended to implement Iowa Code chapter 249A.  
[ARC 9649B, IAB 8/10/11, effective 8/1/11; ARC 4165C, IAB 12/5/18, effective 1/9/19]

**441—77.27(249A) Birth centers.** Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.28(249A) Area education agencies.** An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

**77.28(1)** Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

**77.28(2)** Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

**77.28(3)** Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

**77.28(4)** Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(3);
- b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
- c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
- d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

**77.28(5)** Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

**77.28(6)** Personnel providing vision services shall be:

- a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
- b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 1807C, IAB 1/7/15, effective 3/1/15]

**441—77.29(249A) Case management provider organizations.** Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

**77.29(1) Standards in 441—Chapter 24.** Providers shall be accredited as case management providers pursuant to 441—Chapter 24 as a condition of providing case management services to persons with an intellectual disability, developmental disabilities or chronic mental illness.

**77.29(2) Standards in 441—Chapter 186.** Rescinded IAB 10/12/05, effective 10/1/05.  
[ARC 3184C, IAB 7/5/17, effective 8/9/17]

**441—77.30(249A) HCBS health and disability waiver service providers.** HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

**77.30(1) Homemaker providers.** Homemaker providers shall be agencies that are:

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.30(2) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program.

**77.30(3) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.30(4) Nursing care providers.** Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

**77.30(5) Respite care providers.**

- a. The following agencies may provide respite services:
  - (1) Home health agencies that are certified to participate in the Medicare program.
  - (2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
  - (3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
  - (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
  - (5) Camps certified by the American Camping Association.
  - (6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
  - (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).
  - (8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
  - (9) Assisted living programs certified by the department of inspections and appeals.
- b. Respite providers shall meet the following conditions:
  - (1) Providers shall maintain the following information that shall be updated at least annually:
    1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

*c.* A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

*d.* Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.30(6) Counseling providers.** Counseling providers shall be:

*a.* Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

*b.* Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

*c.* Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.30(7) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

- a.* An individual who contracts with the member to provide attendant care service and who is:
- (1) At least 18 years of age.
  - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
  - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
  - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

- c. Home health agencies which are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.93.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.30(8) *Interim medical monitoring and treatment providers.***

- a. The following providers may provide interim medical monitoring and treatment services:
  - (1) Home health agencies certified to participate in the Medicare program.
  - (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).
- b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:
  - (1) Be at least 18 years of age.
  - (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
  - (3) Not be a usual caregiver of the member.
  - (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.30(9) *Home and vehicle modification providers.*** The following providers may provide home and vehicle modification:

- a. Area agencies on aging as designated in 17—4.4(231).
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
- d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

**77.30(10) *Personal emergency response system providers.*** Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

**77.30(11) *Home-delivered meals.*** The following providers may provide home-delivered meals:

- a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Restaurants licensed and inspected under Iowa Code chapter 137F.
- e. Hospitals enrolled as Medicaid providers.
- f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
- g. Medical equipment and supply dealers certified to participate in the Medicaid program.
- h. Home care providers meeting the standards set forth in subrule 77.33(4).

**77.30(12) *Nutritional counseling.*** The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

- a. Hospitals enrolled as Medicaid providers.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Home health agencies certified by Medicare.
- e. Independent licensed dietitians approved by an area agency on aging.

**77.30(13) *Financial management service.*** Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

- a. The financial institution shall either:
  - (1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or
  - (2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).
- b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.
- c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.
- d. The financial institution shall enroll as a Medicaid provider.

**77.30(14) *Independent support brokerage.*** Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

- a. The broker must be at least 18 years of age.
- b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.
- c. The broker shall not provide any other paid service to the member.
- d. The broker shall not work for an individual or entity that is providing services to the member.
- e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.
- f. The broker must complete independent support brokerage training approved by the department.

**77.30(15) *Self-directed personal care.*** Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

- a. A business providing self-directed personal care services shall:
  - (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and
  - (2) Have current liability and workers' compensation coverage.
- b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.
- c. All personnel providing self-directed personal care services shall:
  - (1) Be at least 16 years of age.
  - (2) Be able to communicate successfully with the member.
  - (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
  - (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
  - (5) Not be the parent or stepparent of a minor child member or the spouse of a member.
- d. The provider of self-directed personal care services shall:
  - (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(16) Individual-directed goods and services.** Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(17) Self-directed community supports and employment.** Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

a. A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(18) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

*a. Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.

3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—77.31(249A) Occupational therapists.** Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

**77.31(1)** Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

**77.31(2)** Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.32(249A) Hospice providers.** Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.33(249A) HCBS elderly waiver service providers.** HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

**77.33(1) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.33(2) Emergency response system providers.** Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

**77.33(3) Home health aide providers.** Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

**77.33(4) Homemaker providers.** Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.33(5) Nursing care.** Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

**77.33(6) Respite care providers.**

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.33(7) *Chore providers.*** The following providers may provide chore services:

a. Home health agencies certified under Medicare.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

f. Community businesses that are engaged in the provision of chore services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

**77.33(8) *Home-delivered meals.*** The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

**77.33(9) *Home and vehicle modification providers.*** The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

**77.33(10) *Mental health outreach providers.*** Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

**77.33(11) *Transportation providers.*** The following providers may provide transportation:

*a.* Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Regional transit agencies as recognized by the Iowa department of transportation.

*d.* Rescinded IAB 3/10/99, effective 5/1/99.

*e.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*f.* Transportation providers contracting with the nonemergency medical transportation contractor.

**77.33(12) *Nutritional counseling.*** The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

*a.* Hospitals enrolled as Medicaid providers.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*d.* Home health agencies certified by Medicare.

*e.* Independent licensed dietitians.

**77.33(13) *Assistive device providers.*** The following providers may provide assistive devices:

*a.* Medicaid-enrolled medical equipment and supply dealers.

*b.* Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).

*c.* Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

*d.* Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

**77.33(14) *Senior companions.*** Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

**77.33(15) *Consumer-directed attendant care providers.*** The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

*h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.33(16) *Financial management service.*** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.33(17) *Independent support brokerage.*** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.33(18) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.33(19) *Individual-directed goods and services.*** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.33(20) *Self-directed community supports and employment.*** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

**77.33(21) *Case management providers.*** A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

- a. The case management provider shall be an agency or individual that:
  - (1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or
  - (2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or
  - (3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or
  - (4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or
  - (5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or
  - (6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:
    1. Meets the qualifications for case managers in 641—subrule 80.6(1); and
    2. Provides a current IDPH local public health services contract number.
- b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:
  - (1) Specific procedures to identify conflicts of interest.
  - (2) Procedures to eliminate any conflict of interest that is identified.
  - (3) Procedures for handling complaints of conflict of interest, including written documentation.
- c. If the case management provider organization subcontracts case management services to another entity:
  - (1) That entity must also meet the provider qualifications in this subrule; and
  - (2) The contractor is responsible for verification of compliance.

**77.33(22) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. *Definitions.*

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*"Minor incident"* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

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

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.33(23) Assisted living on-call service.** Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

This rule is intended to implement Iowa Code section 249A.4.

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**441—77.34(249A) HCBS AIDS/HIV waiver service providers.** HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

**77.34(1) Counseling providers.** Counseling providers shall be:

*a.* Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

*b.* Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

*c.* Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.34(2) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program.

**77.34(3) Homemaker providers.** Homemaker providers shall be agencies that are:

*a.* Certified as a home health agency under Medicare, or

*b.* Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.34(4) Nursing care providers.** Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

**77.34(5) Respite care providers.**

*a.* The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.

(3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).

(8) Assisted living programs certified by the department of inspections and appeals.

*b.* Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

*c.* A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

*d.* Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.34(6) Home-delivered meals.** The following providers may provide home-delivered meals:

*a.* Home health aide providers meeting the standards set forth in subrule 77.34(2).

*b.* Home care providers meeting the standards set forth in subrule 77.34(3).

*c.* Hospitals enrolled as Medicaid providers.

*d.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*e.* Restaurants licensed and inspected under Iowa Code chapter 137F.

*f.* Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

*g.* Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on

aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

*h.* Medical equipment and supply dealers certified to participate in the Medicaid program.

**77.34(7) *Adult day care providers.*** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.34(8) *Consumer-directed attendant care providers.*** The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the member to provide attendant care service and who is:

- (1) At least 18 years of age.
- (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
- (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
- (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

*h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.34(9) *Financial management service.*** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.34(10) *Independent support brokerage.*** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.34(11) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.34(12) *Individual-directed goods and services.*** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.34(13) *Self-directed community supports and employment.*** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

**77.34(14) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

*a.* *Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

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

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

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until

the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.

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**441—77.35(249A) Federally qualified health centers.** Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.36(249A) Advanced registered nurse practitioners.** Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

**77.36(1)** Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

**77.36(2)** Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

**77.36(3)** Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.37(249A) Home- and community-based services intellectual disability waiver service providers.** Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15) "a"(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS intellectual disability waiver service providers.

**77.37(1) Organizational standards (Outcome 1).** Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

**77.37(2) Rights and dignity.** Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

*p.* (Outcome 17) Consumers maintain good health.

*q.* (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

*r.* (Outcome 19) The consumer's desire for intimacy is respected and supported.

*s.* (Outcome 20) Consumers have an impact on the services they receive.

**77.37(3) *Contracts with consumers.*** The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

*a.* The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

*b.* Contracts shall be reviewed at least annually.

**77.37(4) *The right to appeal.*** Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

**77.37(5) *Storage and provision of medication.*** If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

**77.37(6) *Research.*** If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

**77.37(7) *Abuse reporting requirements.*** The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

**77.37(8) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

*a. Definitions.*

*"Major incident"* means an occurrence involving a consumer during service provision that:

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

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

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

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*"Minor incident"* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

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

5. Constitutes a prescription medication error.

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

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff consumer's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

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

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

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.37(9)** *Intake, admission, service coordination, discharge, and referral.*

*a.* The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

*b.* The provider shall ensure the rights of persons applying for services.

**77.37(10)** *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

- a. Rescinded IAB 9/1/04, effective 11/1/04.
- b. Rescinded IAB 9/1/04, effective 11/1/04.
- c. Rescinded IAB 9/1/04, effective 11/1/04.
- d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:
  - (1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.
  - (2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.37(11) *Initial certification.*** The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

- (1) The application for status as an approved provider according to requirements of rules.
- (2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.
- (3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.
- (4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

c. Providers applying for initial certification shall be offered technical assistance.

**77.37(12) *Period of certification.*** Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e."

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

**77.37(13) Review of providers.** Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13) "e" and 77.37(13) "f."

h. The department may conduct a site visit to verify all or part of the information submitted.

**77.37(14) Supported community living providers.**

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

- d.* All supported community living providers shall meet the following requirements:
- (1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:
    1. Implementation of necessary staff training and consumer input.
    2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.
  - (2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.
- e.* The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.
- f.* The department shall approve a living unit designed to serve five persons if both of the following conditions are met:
- (1) Approval will not result in an overconcentration of supported community living units in a geographic area.
  - (2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:
    1. The quantity of services currently available in the county is insufficient to meet the need;
    2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
    3. Approval will result in a reduction in the size or quantity of larger congregate settings.
- 77.37(15) Respite care providers.**
- a.* The following agencies may provide respite services:
- (1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
  - (2) Nursing facilities, intermediate care facilities for persons with an intellectual disability, and hospitals enrolled as providers in the Iowa Medicaid program.
  - (3) Residential care facilities for persons with an intellectual disability licensed by the department of inspections and appeals.
  - (4) Home health agencies that are certified to participate in the Medicare program.
  - (5) Camps certified by the American Camping Association.
  - (6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).
  - (7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
  - (8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).
  - (9) Assisted living programs certified by the department of inspections and appeals.
- b.* Respite providers shall meet the following conditions:
- (1) Providers shall maintain the following information that shall be updated at least annually:
    1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
    2. An emergency medical care release.
    3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
    4. The consumer's medical issues, including allergies.
    5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
  - (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.37(16) Supported employment providers.**

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation for similar services.

(3) An agency that is accredited by the Joint Commission for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

d. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

**77.37(17) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

*a.* Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

*b.* Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

*c.* Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.37(18) Personal emergency response system providers.** Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

**77.37(19) Nursing providers.** Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

**77.37(20) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

**77.37(21) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

*h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.37(22) Interim medical monitoring and treatment providers.**

*a.* The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

*b.* Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

- (1) Be at least 18 years of age.
- (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
- (3) Not be a usual caregiver of the member.
- (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

*c.* Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.37(23)** *Residential-based supported community living service providers.*

*a.* The department shall contract only with public or private agencies to provide residential-based supported community living services.

*b.* Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

- (1) Agencies licensed as group living foster care facilities under 441—Chapter 114.
- (2) Agencies licensed as residential facilities for children with an intellectual disability or brain injury under 441—Chapter 116.
- (3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's intellectual disabilities and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every three years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.

- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.

2. Goals to be achieved to meet the needs of the child.

3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.

4. Specific service activities to be provided to achieve the objectives.

5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.

6. Date of service initiation and date of individual service plan development.

7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.

2. Progress toward goals and objectives is not being made.

3. Changes have occurred in the identified service needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.

4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up

to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

- (1) Rescinded IAB 8/7/02, effective 10/1/02.
- (2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.
- (3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:
  1. How the transition will occur.
  2. What physical change will need to take place in the living units.
  3. How children and their families will be involved in the transitioning process.
  4. How this transition will affect children's social and educational environment.
- f. Certification process and review of service providers.
  - (1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).
  - (2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).
  - (3) Period and conditions of certification.
    1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.
    2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.
  3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.
  4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e" and numbered paragraph 77.37(23) "f"(3) "4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f" and numbered paragraph 77.37(23) "f"(3) "4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h" and subparagraph 77.37(23) "f"(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

**77.37(24) Transportation service providers.** The following providers may provide transportation:

- a. Accredited providers of home- and community-based services.
- b. Regional transit agencies as recognized by the Iowa department of transportation.
- c. Transportation providers that contract with county governments.
- d. Community action agencies as designated in Iowa Code section 216A.93.
- e. Nursing facilities licensed under Iowa Code chapter 135C.
- f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- g. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.37(25) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.37(26) Prevocational service providers.**

- a. Providers of prevocational services must be accredited by one of the following:
  - (1) The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.
  - (2) The Council on Quality and Leadership accreditation in supports for people with disabilities.
- b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
  - (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
  - (2) Member vacation, sick leave and holiday compensation.
  - (3) Procedures for payment schedules and pay scale.

- (4) Procedures for provision of workers' compensation insurance.
- (5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.

(4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

**77.37(27) Day habilitation providers.** Day habilitation services may be provided by agencies meeting the qualifications in subrule 77.25(7).

**77.37(28) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.37(29) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.37(30) Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.37(31) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.37(32) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5361C, IAB 12/30/20, effective 3/1/21]

**441—77.38(249A) Assertive community treatment.** Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

**77.38(1) Minimum composition.** At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

**77.38(2) Psychiatrists.** A psychiatrist on the team shall be a physician (MD or DO) who:

- a. Is licensed under 653—Chapter 9,
- b. Is certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and
- c. Has experience treating serious and persistent mental illness.

**77.38(3) Registered nurses.** A nurse on the team shall:

- a. Be licensed as a registered nurse under 655—Chapter 3, and
- b. Have experience treating persons with serious and persistent mental illness.

**77.38(4) Mental health service providers.** A mental health service provider on the team shall be:

- a. A mental health counselor or marital and family therapist who:
  - (1) Is licensed under 645—Chapter 31, and
  - (2) Has experience treating persons with serious and persistent mental illness; or

*b.* A social worker who:

- (1) Is licensed as a master or independent social worker under 645—Chapter 280, and
- (2) Has experience treating persons with serious and persistent mental illness.

**77.38(5) Psychologists.** A psychologist on the team shall:

- a.* Be licensed under 645—Chapter 240, and
- b.* Have experience treating persons with serious and persistent mental illness.

**77.38(6) Substance abuse treatment professionals.** A substance abuse treatment professional on the team shall:

- a.* Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)“*i*,” and
- b.* Have at least three years of experience treating substance abuse.

**77.38(7) Peer specialists.** A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

**77.38(8) Community support specialists.** A community support specialist on the team shall be a person who:

- a.* Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and
- b.* Has experience supporting persons with serious and persistent mental illness.

**77.38(9) Case managers.** A case manager on the team shall be a person who:

- a.* Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),
- b.* Has experience managing care for persons with serious and persistent mental illness, and
- c.* Meets the qualifications of “qualified case managers and supervisors” in rule 441—24.1(225C).

**77.38(10) Advanced registered nurse practitioners.** An advanced registered nurse practitioner on the team shall:

- a.* Be licensed under 655—Chapter 7,
- b.* Have a mental health certification, and
- c.* Have experience treating serious and persistent mental illness.

**77.38(11) Physician assistants.** A physician assistant on the team shall:

- a.* Be licensed under 645—Chapter 326,
- b.* Have experience treating persons with serious and persistent mental illness, and
- c.* Practice under the supervision of a psychiatrist.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

**441—77.39(249A) HCBS brain injury waiver service providers.** Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department’s brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the

consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS brain injury waiver service providers.

**77.39(1) Organizational standards (Outcome 1).** Organizational outcome-based standards for HCBS BI providers are as follows:

*a.* The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

*b.* The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

*c.* The organization establishes and maintains fiscal accountability.

*d.* The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

*e.* The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

*f.* The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

*g.* Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

*h.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

*i.* The governing body has an active role in the administration of the agency.

*j.* The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

**77.39(2) Rights and dignity.** Outcome-based standards for rights and dignity are as follows:

*a.* (Outcome 2) Consumers are valued.

*b.* (Outcome 3) Consumers live in positive environments.

- c. (Outcome 4) Consumers work in positive environments.
- d. (Outcome 5) Consumers exercise their rights and responsibilities.
- e. (Outcome 6) Consumers have privacy.
- f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g. (Outcome 8) Consumers decide which personal information is shared and with whom.
- h. (Outcome 9) Consumers make informed choices about where they work.
- i. (Outcome 10) Consumers make informed choices on how they spend their free time.
- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

**77.39(3) *The right to appeal.*** Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

**77.39(4) *Storage and provision of medication.*** If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

**77.39(5) *Research.*** If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

**77.39(6) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

*a. Definitions.*

*"Major incident"* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*"Minor incident"* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

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

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.39(7) Intake, admission, service coordination, discharge, and referral.**

*a.* The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

**77.39(8) Certification process.** Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.39(9) Initial certification.** The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification shall be offered technical assistance.

**77.39(10) Period of certification.** Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:  
(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11) "d."

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11) "e."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11) "f."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

**77.39(11) Departmental reviews.** Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11) "c" and "d."

f. The department may conduct a site visit to verify all or part of the information submitted.

**77.39(12) Case management service providers.** Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

**77.39(13) Supported community living providers.**

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

*e.* The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

*f.* The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

**77.39(14) Respite service providers.** Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

*a.* The following agencies may provide respite services:

- (1) Respite providers certified under the HCBS intellectual disability waiver.
- (2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).
- (3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (4) Camps certified by the American Camping Association.
- (5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- (7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
- (8) Home health agencies that are certified to participate in the Medicare program.
- (9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).
- (10) Assisted living programs certified by the department of inspections and appeals.

*b.* Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually:
  1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
  2. An emergency medical care release.
  3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
  4. The consumer's medical issues, including allergies.
  5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.39(15) Supported employment providers.**

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation for similar services.

(3) An agency that is accredited by the Joint Commission for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

d. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

**77.39(16) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

*a.* Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

*b.* Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.39(17) *Personal emergency response system providers.*** Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

*a.* Providers shall be certified annually.

*b.* The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

**77.39(18) *Transportation service providers.*** This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

*a.* Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Regional transit agencies as recognized by the Iowa department of transportation.

*d.* Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

*e.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*f.* Transportation providers contracting with the nonemergency medical transportation contractor.

**77.39(19) *Specialized medical equipment providers.*** The following providers may provide specialized medical equipment:

*a.* Medical equipment and supply dealers participating as providers in the Medicaid program.

*b.* Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

**77.39(20) *Adult day care providers.*** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.39(21) *Family counseling and training providers.*** Family counseling and training providers shall be one of the following:

*a.* Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*b.* Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*c.* Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*d.* Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*e.* Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

*f.* Agencies which are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

**77.39(22) Prevocational services providers.**

*a.* Providers of prevocational services must be accredited by one of the following:

(1) The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(2) The Council on Quality and Leadership accreditation in supports for people with disabilities.

*b.* Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

*c.* Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

**77.39(23) Behavioral programming providers.** Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

*a.* Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

*b.* Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

(6) Agencies which are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

(7) Individuals who meet the definition of "qualified brain injury professional" as set forth in rule 441—83.81(249A).

**77.39(24) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
  - (1) At least 18 years of age.
  - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
  - (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
  - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- c. Home health agencies which are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.93.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.39(25) Interim medical monitoring and treatment providers.**

- a. The following providers may provide interim medical monitoring and treatment services:
  - (1) Home health agencies certified to participate in the Medicare program.
  - (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).
- b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:
  - (1) Be at least 18 years of age.
  - (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
  - (3) Not be a usual caregiver of the member.
  - (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.39(26) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.39(27) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.39(28) Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.39(29) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.39(30) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 1638C, IAB 10/1/14, effective 11/5/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4792C, IAB 12/4/19, effective 1/8/20]

**441—77.40(249A) Lead inspection agencies.** The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.41(249A) HCBS physical disability waiver service providers.** Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers. The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS physical disability waiver service providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

**77.41(1) Enrollment process.** Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

- a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.
- b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.41(2) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide consumer-directed attendant care and who is:

- (1) At least 18 years of age.
- (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
- (3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
- (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

- c. Home health agencies that are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.103.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.41(3)** *Home and vehicle modification providers.* The following providers may provide home and vehicle modifications:

- a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
- b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.41(4)** *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

**77.41(5)** *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

- a. Medical equipment and supply dealers participating as providers in the Medicaid program.
- b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

**77.41(6)** *Transportation service providers.* The following providers may provide transportation:

- a. Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Regional transit agencies as recognized by the Iowa department of transportation.
- d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- e. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.41(7)** *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.41(8)** *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.41(9)** *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.41(10)** *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.41(11)** *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

**77.41(12)** *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

- a. *Definitions.*

*“Major incident”* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

*“Minor incident”* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

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

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.

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

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—77.42(249A) Public health agencies.** Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

**441—77.43(249A) Infant and toddler program providers.** An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

**77.43(1) Licensure.** Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

*a.* Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

*b.* Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

*c.* Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

*d.* Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

*e.* Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

- f.* Personnel providing vision services shall be:
- (1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
  - (2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
  - (3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.
- g.* Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).
- h.* Medical transportation shall be provided by licensed drivers.
- i.* Other services shall be provided by staff who are:
- (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
  - (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
  - (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
  - (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
  - (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
  - (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
  - (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
  - (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
  - (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
  - (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

**77.43(2) Documentation requirements.** As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

- a.* Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b.* An assessment and response to interventions and services.
- c.* An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).
- d.* Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

This rule is intended to implement Iowa Code section 249A.4.

**441—77.44(249A) Local education agency services providers.** School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

**77.44(1) Licensure.** Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

*a.* Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

*b.* Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

*c.* Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

*d.* Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

*e.* Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

*f.* Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

*g.* Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

*h.* Medical transportation shall be provided by licensed drivers.

*i.* Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

**77.44(2) Documentation requirements.** As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

- a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b. An assessment and response to interventions and services.
- c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

This rule is intended to implement Iowa Code section 249A.4.

**441—77.45(249A) Indian health facilities.** A health care facility operated by the U.S. Indian Health Service or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an "Indian tribe," "tribal organization," or "Urban Indian organization," as those terms are defined in 25 U.S.C. 1603, is eligible to participate in the medical assistance program if the following conditions are met:

**77.45(1) Licensure.** Services must be rendered by practitioners who meet applicable professional licensure requirements.

**77.45(2) Documentation.** Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 2930C, IAB 2/1/17, effective 4/1/17]

**441—77.46(249A) HCBS children's mental health waiver service providers.** HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

**77.46(1) General provider standards.** All providers of HCBS children's mental health waiver services shall meet the following standards:

a. *Fiscal capacity.* Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. *Direct care staff.*

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. *Outcome-based standards and quality assurance.*

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.

2. Consumers are a part of community life.

3. Consumers develop meaningful goals.

4. Consumers maintain physical and mental health.

5. Consumers are safe.

6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

*d. Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION: The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

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

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care

organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.46(2)** *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

- a. A community business that:
  - (1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and
  - (2) Submits verification of current liability and workers' compensation insurance.
- b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.
- c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.
- d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.
- e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

**77.46(3)** *Family and community support services providers.*

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

- (1) Behavioral health intervention providers qualified under 441—77.12(249A).
- (2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)“c” for the children's mental health waiver.
- (2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
2. Confidentiality;
3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*d. Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

**77.46(4) In-home family therapy providers.**

*a. Qualified providers.* The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

*b. Staff training.* The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1)“c” for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*d. Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

**77.46(5) Respite care providers.**

*a. Qualified providers.* The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Camps certified in good standing by the American Camping Association.

(4) Home health agencies that are certified in good standing to participate in the Medicare program.

(5) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(6) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(7) Assisted living programs certified in good standing by the department of inspections and appeals.

(8) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(9) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

*b. Staff training.* The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and
2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1) "c."

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Consumer-specific information.* The following information must be written, current, and accessible to the respite provider during service provision:

- (1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

- (2) The consumer's typical schedule.

- (3) The consumer's preferences in activities and foods or any other special concerns.

- (4) The consumer's crisis intervention plan.

*d. Written notification of injury.* The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

*e. Medication dispensing.* Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

*f. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

- (1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

- (2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

- (3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

- (4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*g. Service documentation.* Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

*h. Capacity.* A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

*i. Service provided outside home or facility.* For respite care to be provided in a location other than the consumer's home or the provider's facility:

- (1) The care must be approved by the parent, guardian or usual caregiver;
- (2) The care must be approved by the interdisciplinary team in the consumer's service plan;
- (3) The care must be consistent with the way the location is used by the general public; and
- (4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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**441—77.47(249A) Health home services providers.** Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

**77.47(1) Qualifications.** A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

*a. Staffing.* At a minimum, a qualifying provider must fill the following roles:

- (1) Designated practitioner.
- (2) Dedicated care coordinator.
- (3) Health coach.
- (4) Clinic support staff.

*b. Data management.* A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

*c. Collaboration with case managers.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

*d. Provision of integrated health home services.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(3) or (4) must be integrated health homes that:

- (1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);
- (2) Have a direct agreement with an Iowa Medicaid managed care organization to provide health home services for members with SMI or SED;
- (3) Coordinate all community and social support services needs for members enrolled in the health home; and
- (4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

**77.47(2) Report on quality measures.** As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

**77.47(3) Selection.** As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member’s health home, as reported by provider attestation.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—77.48(249A) Speech-language pathologists.** Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

**77.48(1)** Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

**77.48(2)** Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

**441—77.49(249A) Physician assistants.** All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation.

This rule is intended to implement Iowa Code section 249A.4. [ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 5418C, IAB 2/10/21, effective 4/1/21]

**441—77.50(249A) Ordering and referring providers.** A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider’s payment arrangements with such facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4. [ARC 0580C, IAB 2/6/13, effective 4/1/13]

**441—77.51(249A) Child care medical services.** Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

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

**441—77.52(249A) Community-based neurobehavioral rehabilitation services.**

**77.52(1) Definitions.**

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Brain injury*” means a diagnosis in accordance with rule 441—83.81(249A).

“*Health care*” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“*Intermittent community-based neurobehavioral rehabilitation services*” means services provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and

accommodate to challenging behaviors to support the member to remain in the member's own home and community.

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

*"Neurobehavioral rehabilitation"* refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

*"Program"* means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

*"Standardized assessment"* means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's needs.

**77.52(2) Eligible providers.** The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

a. An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

b. Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

**77.52(3) Provider standards.** All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

a. The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

(1) The organization shall provide high-quality supports and services to members.

(2) The organization shall have a defined mission commensurate with members' needs, desires, and abilities.

(3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.

(4) The program administrator shall be a certified brain injury specialist trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department. The administrator shall be present in the assigned location for 25 hours per week. In the event of an absence from the assigned location exceeding four weeks, the organization shall designate a qualified replacement to act as administrator for the duration of the assigned administrator's absence.

(5) A minimum of 75 percent of the organization's administrative and direct care personnel shall meet one of the following criteria:

1. Have a bachelor's degree in a human services-related field;

2. Have an associate's degree in human services with two years of experience working with individuals with brain injury;

3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or

4. Be a certified brain injury specialist (CBIS) certified through the Academy for the Certification of Brain Injury Specialists (ACBIS) or have other nationally recognized brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served.

Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members, including but not limited to:

1. Promotion of a program structure and support for persons served so they can re-learn or regain skills for community inclusion and access.
2. Compensatory strategies to assist in managing ADLS (activities of daily living).
3. Quality of life issues.
4. Behavioral supports and identification of antecedent triggers.
5. Health and medication management.
6. Dietary and nutritional programming.
7. Assistance with identifying and utilizing assistive technology.
8. Substance abuse and addiction issues.
9. Self-management and self-interaction skills.
10. Flexibility in programming to meet members' individual needs.
11. Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial and medical needs.
12. Community accessibility and safety.
13. Household maintenance.
14. Service support to the member's family or support system related to the member's neurobehavioral care.

*b.* The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum the training includes the following:

- (1) Completion of the department-approved brain injury training modules.
- (2) Member rights.
- (3) Confidentiality and privacy.
- (4) Dependent adult and child abuse prevention and mandatory reporter training.
- (5) Individualized rehabilitation treatment plans.
- (6) Major mental health disorder basics.

*c.* Within 30 days of commencement of direct service provision, employees shall complete nationally recognized cardiopulmonary resuscitation (CPR) certification, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually, with the exception of CPR certification, which must be renewed prior to expiration of the certification.

*d.* Within the first six months of commencement of direct service provision, employees shall complete training required by subparagraph 77.52(3) "a"(6).

*e.* Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training. A majority of eligible employees within 12 months of the commencement of direct service provision shall be CBISs certified through ACBIS or have other nationally recognized brain injury certification as approved by the department.

*f.* The organization shall have in place an outcome management system which measures the efficiency and effectiveness of service provision, including members' preadmission location of service, length of stay, discharge location, reason for discharge, member and stakeholder satisfaction, and access to services.

*g.* The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

- (1) Measure and analyze organizational activities and services quarterly.
- (2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.
- (3) Conduct an internal review of member service records at regular intervals.

(4) Track major and minor incident data according to subrule 77.37(8) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof; and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.

(5) Continuously identify areas in need of improvement.

(6) Develop a plan to address the identified areas in need of improvement.

(7) Implement the plan, document the results, and report to the governing body annually.

*h.* The organization shall have in place written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

*i.* The organization's governing body shall have an active role in the administration of the organization.

*j.* The organization's governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall provide oversight that ensures the provision of high-quality supports and services to members.

*k.* The organization shall implement the following outcome-based standards for rights and dignity:

(1) Members are valued.

(2) The member and the member's treatment team mutually develop an individualized service plan (ISP) that takes into account the member's individual strengths, barriers and interests. The service plan shall include goals which are based on the member's need for services and shall address the neurobehavioral challenges and environmental needs as identified in the member's individual standardized comprehensive functional neurobehavioral assessment.

(3) The member and the member's treatment team evaluate the member's progress towards treatment goals regularly and no less than quarterly. Treatment plans are reviewed regularly, but not less than quarterly, and are revised as the member's status or needs change to reflect the member's progress and response to treatment.

(4) The member and the member's legal representative have the right to file grievances regarding the provider's implementation of the organizational standards, or its employee's or contractual person's action which affects the member. The provider shall provide to members the policies and procedures for member grievances and appeals at the commencement of services and annually thereafter.

(5) When a member requires any restrictive interventions, the interventions will be implemented in accordance with rules 481—63.21(135C), 481—63.27(135C), and 481—63.28(135C). When a member has a guardian or legal representative, the guardian or legal representative shall provide informed consent to treat and consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

1. Restraint, including chemical restraint, manual restraint or mechanical restraint;

2. Alarms added to a member's natural environment including doors, windows, refrigerators, cabinets, and other home appliances and fixtures;

3. Exclusionary time out;

4. Intensive staffing for control of behavior;

5. Limited access or contingency access to preferred items or activities naturally available in the member's environment;

6. Reprimand;

7. Response cost; and

8. Use of psychotropic medications to control the occurrence of an unwanted behavior.

(6) Members receive individualized services.

(7) Members or their legal representatives provide written consent regarding which personal information is shared and with whom.

(8) Members receive assistance with accessing financial management services as needed.

(9) Members receive assistance with obtaining preventive, appropriate and timely medical and dental care.

(10) The member's living environment is reasonably safe and located in the community.

(11) The member's desire for intimacy is respected and supported.  
[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20]

**441—77.53(249A) Qualified Medicare beneficiary (QMB) providers.** Any Medicare provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a QMB provider.

**77.53(1) Reimbursement.** A QMB provider may only bill the department for the QMB-eligible member's Medicare cost-sharing obligations. Reimbursement is limited to coinsurance, copayments, and deductibles for Medicare-covered services.

**77.53(2) Definitions.**

*"Coinsurance"* means a percentage of costs of a covered health care service that has to be paid.

*"Copayment"* means a fixed amount a member pays for a covered health care service.

*"Deductible"* means the amount paid for covered health care services before the insurance plan will effect payment.

*"Medicare cost sharing"* means the Medicare member's responsibility for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

*"Qualified Medicare beneficiary"* or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

**441—77.54(249A) Health insurance premium payment (HIPP) providers.** Any provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a HIPP provider. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance paid for through the HIPP program.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

**441—77.55(249A) Crisis response services.**

**77.55(1) Definitions.** The terms used in this rule shall have the same meaning as set out in 441—Chapter 24, Division II.

**77.55(2) Eligible providers.** Agencies which are accredited under the mental health service provider standards established by the mental health and disability services commission, set forth in 441—Chapter 24, Division II, are eligible to participate in the program by providing crisis response services, crisis stabilization community-based services, and crisis stabilization residential services.

**77.55(3) Provider standards.** All providers of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services shall meet the standards criteria as set forth in 441—Chapter 24, Division II.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

**441—77.56(249A) Subacute mental health services.**

**77.56(1) Definitions.** The terms used in this rule shall have the same meaning as set out in Iowa Code section 135G.1.

**77.56(2) Subacute mental health services.** Subacute mental health services are intended to be short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

**77.56(3) Eligible provider.** Subacute mental health care facilities which are licensed by the department of inspections and appeals in accordance with 481—Chapter 71 are eligible to participate in the program by providing subacute mental health services.

**77.56(4) Provider standards.** All providers of subacute mental health services shall meet the standards criteria as set forth in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

**441—77.57(249A) Pharmacists.** An authorized pharmacist licensed to practice in the state of Iowa is eligible to participate in the program.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 5175C, IAB 9/9/20, effective 6/1/21]

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<sup>1</sup> Two ARCs

- <sup>2</sup> December 15, 2002, effective date of 77.37(14)“e”(2) and 77.39(13)“e” delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

CHAPTER 78  
AMOUNT, DURATION AND SCOPE OF  
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

[Prior to 2/11/87, Human Services[498]]

**441—78.1(249A) Physicians' services.** Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

**78.1(1)** Payment will not be made for:

*a.* Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

*b.* Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

*c.* Treatment of certain foot conditions as specified in 78.5(2) "a," "b," and "c."

*d.* Acupuncture treatments.

*e.* Rescinded 9/6/78.

*f.* Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

*g.* Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the IME medical services unit or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the IME medical services unit and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The IME medical services unit may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

*h.* Elective, non-medically necessary cesarean section (C-section) deliveries.

**78.1(2)** Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

*a.* Drugs are covered as provided by rule 441—78.2(249A).

*b.* Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

*c.* Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

*d.* Rescinded IAB 1/30/08, effective 4/1/08.

*e.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

*f.* Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

**78.1(3)** Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

*a.* Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

*b.* Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)“a”(3).

*c.* Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

*d.* Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

*e.* Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

*f.* Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

*g.* Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

**78.1(4)** For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

*a.* Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

*b.* Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

*c.* When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

*d.* Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

*e.* Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

**78.1(5)** The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

**78.1(6)** Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

**78.1(7)** No payment shall be made for the services of a private duty nurse.

**78.1(8)** Payment for mileage shall be the same as that in effect in part B of Medicare.

**78.1(9)** Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

*a.* Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

*b.* When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

*c.* Payment will be approved for mileage in connection with nursing home visits when:

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

*d.* Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a 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, 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 in 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—Chapters 326 to 329 is exempt from the direct personal supervision requirement except as expressly required by Iowa Code chapter 148C or required by rules in 645—Chapters 326 to 329. A physician shall be accessible at all times for consultation with a physician assistant unless the physician assistant is providing emergency medical services pursuant to 645—paragraph 327.1(2) “*n.*” 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(4))

**78.1(19)** Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the IME medical services unit and the

department. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

**78.1(20) Transplants.**

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary atresia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f") Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f") Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

*b.* Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

*c.* All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

*d.* Payment will not be made for any transplant not specifically listed in paragraph “*a.*”

**78.1(21)** Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term “physician” does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

**78.1(22)** Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

*a.* If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

*b.* If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

**78.1(23)** EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

**78.1(24)** Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

*a.* Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

*b.* Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

*c.* Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician’s supervision that this application is not a substitute for comprehensive dental care.

*d.* Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

**78.1(25)** Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0846C**, IAB 7/24/13, effective 7/1/13; **ARC 1052C**, IAB 10/2/13, effective 11/6/13; **ARC 1297C**, IAB 2/5/14, effective 4/1/14; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 5418C**, IAB 2/10/21, effective 4/1/21]

**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 or ordered by an Iowa Medicaid-enrolled practitioner licensed or registered to prescribe as specified in Iowa Code section 155A.3(38).

**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 or drug order, a prescription or drug order shall be transmitted as specified in Iowa Code sections 124.308, 155A.3 and 155A.27 by the practitioner to the pharmacy, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions or drug orders 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.

(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.

(4) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

*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.

(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).

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the U.S. Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4).

**78.2(5) Nonprescription drugs.**

a. The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg  
Acetaminophen elixir 160 mg/5 ml  
Acetaminophen solution 100 mg/ml  
Acetaminophen suppositories 120 mg  
Artificial tears ophthalmic solution  
Artificial tears ophthalmic ointment  
Aspirin tablets 81 mg, chewable  
Aspirin tablets 81 mg, 325 mg, and 650 mg oral  
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  
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 solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)  
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  
Guaiifenesin 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%  
Levonorgestrel 1.5 mg  
Loperamide hydrochloride liquid 1 mg/5 ml  
Loperamide hydrochloride liquid 1 mg/7.5 ml  
Loperamide hydrochloride tablets 2 mg  
Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg  
 Magnesium hydroxide suspension 400 mg/5 ml  
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable  
 Miconazole nitrate cream 2% topical and vaginal  
 Miconazole nitrate vaginal suppositories, 100 mg  
 Mineral products with prior authorization  
 Neomycin-bacitracin-polymyxin ointment  
 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  
 Vitamins, single and multiple with prior authorization  
 Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

*b.* Nonprescription drugs for use in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID.

**78.2(6) Quantity prescribed.**

*a. Quantity prescribed.* When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

*b. Prescription refills.*

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are allowed. Participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis.

2. The program must have:

- Easy-to-locate contact information through telephone, the program's website, or both;
- Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
- Confirmation that the member wants to continue in the automatic refill program at least annually;
- Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the

pharmacy or before the medication is mailed or delivered to the member, without which confirmation the drug(s) must be credited back to the Medicaid program; and

- Records of all consents, which must be in electronic or written format and must be available for review by auditors.

**78.2(7) *Lowest cost item.*** The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

**78.2(8) *Consultation.*** In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5175C, IAB 9/9/20, effective 6/1/21; ARC 5364C, IAB 12/30/20, effective 3/1/21]

**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(6)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

**78.3(1)** Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

**78.3(2)** No payment will be approved for private duty nursing.

**78.3(3)** Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

**78.3(4)** Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

**78.3(5)** Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)“b”(1) to (10) except for 78.2(4)“b”(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

*a.* Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)“b”(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

*b.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**78.3(6)** Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

**78.3(7)** Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

**78.3(8)** Rescinded IAB 2/6/91, effective 4/1/91.

**78.3(9)** Payment will be made for sterilizations in accordance with 78.1(16).

**78.3(10)** Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

*a. Recipient selection and education.*

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

*b. Staffing and resource commitment.*

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.  
Hepatology.  
Immunology.  
Infectious diseases.  
Nephrology.  
Neurology.  
Pathology.  
Pediatrics.  
Psychiatry.  
Pulmonary medicine.  
Radiology.  
Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.  
Blood bank services.  
Cardiology.  
Cardiovascular surgery.  
Dialysis.  
Dietary services.  
Gastroenterology.  
Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.  
Pharmaceutical services.  
Physical therapy.  
Psychiatry.  
Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. *Experience and survival rates.*

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

*d. Organ procurement.* The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

*e. Maintenance of data, research, review and evaluation.*

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

*f. Application procedure.* A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must

specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

*g. Review and approval of facilities.* An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

**78.3(11)** Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

**78.3(12)** Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16) “a” and “r” to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual’s health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient’s medical condition including presenting symptoms and medical history prior to treatment or evaluation.

**78.3(13)** Payment for patients in acute hospital beds who are determined by the IME medical services unit to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

**78.3(14)** Payment for patients in acute hospital beds who are determined by the IME medical services unit to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

**78.3(15)** Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level

of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.

**78.3(16)** Skilled nursing care in “swing beds.”

*a.* Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

*b.* Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

- (1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
- (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) “a.”
- (3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).
- (4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:
  1. Complete a level of care (LOC) determination describing a member’s LOC needs, using Form 470-5156, Swing Bed Certification.
  2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member’s LOC needs.
  3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member’s needs and that home-based care for the member is not available or appropriate.
- (5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an “appropriate” nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member’s medical condition and corresponding LOC needs.
- (6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

**78.3(17)** Rescinded IAB 8/9/89, effective 10/1/89.

**78.3(18)** Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(6))

**78.3(19)** Rescinded IAB 10/8/97, effective 12/1/97.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0844C, IAB 7/24/13, effective 7/1/13; ARC 1054C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**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(3) "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(3)“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(3)“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(3)“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(3) "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(3) "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(3) “c”)

*b.* Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

*c.* Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

**78.4(9) Adjunctive general services.** Payment may be made for the following:

*a.* Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

*b.* Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

*c.* Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

*d.* Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

*e.* Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist’s office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

*f.* Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

*g.* Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

**78.4(10) Orthodontic services to members 21 years of age or older.** Orthodontic procedures are not covered for members 21 years of age or older.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**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(4))

**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; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**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(4))

**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.

[ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.8(249A) Chiropractors.** Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

**78.8(1) *Covered services.*** Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

**78.8(2) *Indications and limitations of coverage.***

*a.* The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

\* NEC means not elsewhere classified.

*b.* The neuromusculoskeletal conditions listed in the table in paragraph “*a*” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

*c.* CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

**78.8(3) Documenting X-ray.** An X-ray must document the primary regions of subluxation being treated by CMT.

*a.* The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph “*c*” of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

*b.* The X-ray films shall be labeled with the patient’s name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient’s clinical record.

*c.* Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which

major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

**441—78.9(249A) Home health agencies.** Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member’s residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) “a” may be provided in settings other than the member’s residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient’s care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member’s community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician’s signature and date on a plan of treatment.

**78.9(1) Treatment plan.** A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. 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 60 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.** Rescinded IAB 3/29/17, effective 5/3/17.

**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, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- (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 intellectual disability.
  - (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) Intellectual disability 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(10))

**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; ARC 3005C, IAB 3/29/17, effective 5/3/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**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 using Form 470-5595, Outpatient Prior Authorization Request. 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.

*b.* The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser.

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.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;
3. Positioning accessories;
4. Specialized skin protection seat and back cushions; and
5. Anti-rollback devices.

(3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:

1. Lap belt or safety belt;

2. Battery charger, single mode;
3. Complete set of tires/wheels and casters, any type;
4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
  - For standard duty, seat width and/or depth greater than 20 inches;
  - For heavy duty, seat width and/or depth greater than 22 inches;
  - For very heavy duty, seat width and/or depth greater than 24 inches;
  - EXCEPTION: For extra heavy duty, there is no separate billing;
9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
  - For standard duty, seat width and/or depth greater than 20 inches;
  - For heavy duty, seat width and/or depth greater than 22 inches;
  - For very heavy duty, seat width and/or depth greater than 24 inches;
  - EXCEPTION: For extra heavy duty, there is no separate billing;
10. Non-expandable controller or standard proportional joystick (integrated or remote); and
11. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:

1. Shoulder harness/straps or chest straps/vest;
2. Elevating legrest;
3. Angle adjustable footplates;
4. Adjustable height armrests; and
5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).

(5) Customized items are payable with a prior authorization, in accordance with 42 CFR §414.224.

**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(5))

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.* Rescinded IAB 12/30/20, effective 3/1/21.

*e.* DME rebate agreements. 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, subject to the requirements of 78.10(2)“d.”

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; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

**441—78.11(249A) Ambulance service.** Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

**78.11(1)** Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

**78.11(2)** The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

**78.11(3)** When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

**78.11(4)** Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) "j."

**78.11(5)** In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.12(249A) Behavioral health intervention.** Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

**78.12(1) Definitions.**

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or "LPHA," as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

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

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

**78.12(2) Covered services.**

a. *Service setting.*

- (1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's

family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

*b. Crisis intervention.* Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

*c. Behavior intervention.* Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

*d. Family training.* Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

*e. Skill training and development.* Skill training and development services are covered for Medicaid members aged 18 or over.

- (1) Skill training and development shall consist of interventions to:
  1. Enhance a member's independent living, social, and communication skills;
  2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
  3. Maximize a member's ability to live and participate in the community.
- (2) Interventions may include training in the following skills for effective functioning with family, peers, and community:
  1. Communication skills,
  2. Conflict resolution skills,
  3. Daily living skills,
  4. Employment-related skills,
  5. Interpersonal relationship skills,
  6. Problem-solving skills, and
  7. Social skills.

**78.12(3) Excluded services.**

*a.* Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

*b.* Respite, day care, education, and recreation services are not covered under behavioral health intervention.

**78.12(4) Coverage requirements.** Medicaid covers behavioral health intervention only when the following conditions are met:

*a.* A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

*b.* The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

- (1) The member's need for services must meet specific individual goals that are focused to address:
  1. Risk of harm to self or others,
  2. Behavioral support in the community,
  3. Specific skills impaired due to the member's mental illness, and
  4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.
- (2) Diagnosis and treatment plan development are covered services.

*c.* For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

*d.* The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

**78.12(5) Approval of plan.** The behavioral health intervention provider shall contact the member's managed care plan 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 member's managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)"a" if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)"c"(3).

**78.12(6) Medical necessity.** Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

*a.* Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

*b.* Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

*c.* The least costly type of service that can reasonably meet the medical needs of the member; and

*d.* In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[ARC 8504B, IAB 2/10/10, effective 3/22/10; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 5305C, IAB 12/2/20, effective 2/1/21]

**441—78.13(249A) Nonemergency medical transportation.** The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

**78.13(1) Covered services.** Nonemergency medical transportation services available are limited to:

*a.* The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

(1) Mileage reimbursement to the member, if the member is the driver.

(2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.

(3) Taxi service.

(4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.

(5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

*b.* Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

*c.* Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

*d.* Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

*e.* Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

**78.13(2) Exclusions.** Nonemergency medical transportation is not available through the Iowa Medicaid program for:

- a.* Transportation to obtain services not covered by Iowa Medicaid;
- b.* Transportation to providers that are not enrolled in Iowa Medicaid;
- c.* Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);
- d.* Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;
- e.* Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;
- f.* Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;
- g.* Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and
- h.* Emergency transportation.

**78.13(3) Conditions and limitations on covered services.** Nonemergency medical transportation services are subject to the following limitations and conditions:

*a. Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;
2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and
3. The other requirements of rule 441—78.13(249A) must be met.

*b. No free transportation alternatives available.* Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

*c. No member transportation alternatives available.* Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

*d. Limitations on reimbursement for meals.* Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

*e. Limitations on reimbursement for lodging expenses.* Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

*f. Closest medical provider.* Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:
  1. The member's previous relationship with the requested provider; or
  2. The member's prior experience with the requested provider; or
  3. The requested provider's special expertise or experience; or
  4. A referral requiring the member to be seen by the requested provider.

*g. Member scheduling obligations.* Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

*h. Abusive behavior.* Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

*i. Member claim submission.* Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

**78.13(4) Grievance procedure.** The broker shall establish an internal grievance procedure for members and transportation providers.

*a.* Members may appeal to the department pursuant to 441—Chapter 7 as an "aggrieved person."

*b.* Transportation providers.

- (1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

**441—78.14(249A) Hearing aids.** Payment shall be approved for a hearing aid and examinations subject to the following conditions:

**78.14(1) Physician examination.** The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

*a.* Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

*b.* Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

**78.14(2) Audiological testings.** A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

**78.14(3) Hearing aid evaluation.** A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

**78.14(4) Hearing aid selection.** A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

**78.14(5) Travel.** When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

**78.14(6) Purchase of hearing aid.** The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

*a.* A child needs the aid for speech development,

*b.* The aid is needed for educational or vocational purposes,

*c.* The aid is for a blind member,

*d.* The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

*e.* Lack of binaural amplification poses a hazard to a member's safety.

**78.14(7) Payment for hearing aids.**

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(5) "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(5) "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; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**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. A nursing facility, an intermediate care facility for persons with an intellectual disability, or a hospital where services are provided is not considered a member's home.

1. Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections and appeals are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.

2. Under no circumstances will the IME or managed care organizations (MCOs) make payments 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. Physical, occupational, and speech therapy services for residents of the nursing facility, intermediate care facility for persons with an

intellectual disability or hospital are the responsibility of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital.

(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; ARC 5305C, IAB 12/2/20, effective 2/1/21]

**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 website.

**78.26(1)** Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

**78.26(2)** Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

**78.26(3)** The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
  - b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A);
- and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

**78.26(4) Limits on covered services.**

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(7))

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.27(249A) Home- and community-based habilitation services.** Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**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.

“*Benefits education*” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“*Care coordinator*” means the professional who assists members in care coordination as described in paragraph 78.53(1) “b.”

“*Career exploration*,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

“*Career plan*” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Comprehensive service plan*” means an individualized, person-centered, and 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.

“*Customized employment*” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a

disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

*“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.

*“Individual employment”* means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

*“Individual placement and support”* means an evidence-based supported employment model that helps people with mental illness to seek and obtain employment.

*“Integrated community employment”* means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

*“Integrated health home”* means the provision of services to enrolled members as described in subrule 78.53(1).

*“Interdisciplinary team”* means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

*“ISIS”* means the department’s individualized services information system.

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

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

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

*“Supported employment”* means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

*“Supported self-employment”* includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“*Sustained employment*” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

**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 interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual’s case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the interRAI, before services begin and annually thereafter.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter.

*e. Plan for service.* The department has approved the member’s comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member’s eligibility for the program cannot be reimbursed.

(1) The member’s comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member’s needs.

(2) The member’s habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

**78.27(3) Application for services.** The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

**78.27(4) Comprehensive service plan.** Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

*a. Development.* A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. 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 with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

*b. Service goals and activities.* The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;

2. The funding source for the service; and

3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;

2. The number of hours per day of on-site staff supervision needed by the member; and

3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

*c. Rights restrictions.* Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member’s rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

*d. Emergency plan.* The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

- (1) The member’s interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.
- (2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member’s needs change.
- (3) Providers of applicable services shall provide for emergency backup staff.

*e. Plan approval.* Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)“e.”

**78.27(5) Requirements for services.** Home- and community-based habilitation services shall be provided in accordance with the following requirements:

- a.* The services shall be based on the member’s needs as identified in the member’s comprehensive service plan.
- b.* The services shall be delivered in the least restrictive environment appropriate to the needs of the member.
- c.* The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member’s life goals.
- d.* Service components that are the same or similar shall not be provided simultaneously.
- e.* Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.
- f.* Reimbursement is not available for room and board.
- g.* Services shall be billed in whole units.
- h.* Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

**78.27(6) Case management.** Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

*a. Scope.* Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(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 services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

*a. Scope.* Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member's individual goals as identified in the member's comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

- (1) Identifying the member's interests, preferences, skills, strengths and contributions,
- (2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
- (3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,
- (4) Developing skills and competencies necessary to pursue competitive integrated employment,
- (5) Participating in community activities related to hobbies, leisure, personal health, and wellness,
- (6) Participating in community activities related to cultural, civic, and religious interests,
- (7) Participating in adult learning opportunities,
- (8) Participating in volunteer opportunities,
- (9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,
- (10) Assistance with behavior management and self-regulation,
- (11) Use of transportation and other community resources,
- (12) Assistance with developing and maintaining natural relationships in the community,
- (13) Assistance with identifying and using natural supports,

(14) Assistance with accessing financial literacy and benefits education,  
(15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

*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. Expected outcome of service.* The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

*d. Setting.* Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.

*e. Duration.* Day habilitation services shall be furnished 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).

*f. Unit of service.* A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

*g. Concurrent services.* A member's comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment, long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

*h. Transportation.* When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

*i. Exclusions.* Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual 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 to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

**78.27(9) Prevocational service habilitation.** "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

*a. Scope.* Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to

participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,

2. Business tours,
3. Informational interviews,
4. Job shadows,
5. Benefits education and financial literacy,
6. Assistive technology assessment, and
7. Job exploration events.

- (2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

- b. Setting.* Prevocational services shall take place in community-based nonresidential settings.

- c. Concurrent services.* A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

- d. Exclusions.* Prevocational services payment shall not be made for the following:

- (1) Services that are available to the individual 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 to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

- (2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

- (3) Compensation to members for participating in prevocational services.

- (4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

- (5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

- (6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

- e. Limitations.*

- (1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9) "a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9) "a"(1). This time limit can be extended as stated in paragraphs 78.27(9) "e"(1) "1" through "6." If the criteria in paragraphs 78.27(9) "e"(1) "1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

**78.27(10) Supported employment services.**

*a. Individual supported employment.* Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.

6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10) "a"(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
  2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
  3. Identification of the long-term supports necessary for the individual to operate the business.
- b. Long-term job coaching.* Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are

adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
  2. Job training and systematic instruction.
  3. Training and support for use of assistive technology/adaptive aids.
  4. Engagement of natural supports.
  5. Transportation coordination.
  6. Job retention training and support.
  7. Benefits education and ongoing support.
  8. Supports for career advancement.
  9. Financial literacy and asset development.
  10. Employer consultation and support.
  11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
  12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
  13. Transportation of the member during service hours.
  14. Career exploration services leading to increased hours or career advancement.
- (5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)“b”(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
  2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
  3. Ongoing benefits education and support.
- (6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member’s comprehensive service plan.

*c. Small-group supported employment.* Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member’s residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.

3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).

4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.

11. Transportation of the member during service hours.

*d. Service requirements for all supported employment services.*

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

*e. Limitations.* Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,059.29 per month.

(3) Individual supported employment is limited to 60 hourly units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

*f. Exclusions.* Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual 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 the service is not available to the individual under these programs shall be maintained

in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, 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 and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

**78.27(11) Adverse service actions.**

*a. Denial.* Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

*b. Reduction.* A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

*c. Termination.* A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 120 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 120 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

*d. Appeal rights.* The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter

requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

**78.27(12) County reimbursement.** Rescinded IAB 7/11/12, effective 7/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21]

**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.* Rescinded IAB 12/30/20, effective 3/1/21.

*c.* Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)“*l.*”

*d.* Rescinded IAB 5/11/05, effective 5/1/05.

*e.* Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)“*f.*”

*f.* Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

*g.* Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)“*a.*”

*h.* Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2)“*c.*”)

*i.* Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)“*m.*”

*j.* Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)“*c.*”

*k.* DME rebate agreements. 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, subject to the requirements of 78.10(2)“*d.*”

**78.28(2)** Notwithstanding the provisions of 78.28(1)“*a.*” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted

treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

- a. Buprenorphine,
- b. Buprenorphine and naloxone combination,
- c. Methadone,
- d. Naltrexone, and
- e. Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

**78.28(3)** Dental services. Dental services which require prior approval are as follows:

- a. The following periodontal services:
  - (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4) “b.”
  - (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4) “d.”
  - (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4) “e.”
  - (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4) “f.”
  - (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4) “g.”
- b. The following prosthetic services:
  - (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “b.”
  - (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “d.”
  - (3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “c.”
  - (4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) “e.”
  - (5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7) “k.”
  - (6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7) “l.”
  - (7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7) “m.”
  - (8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7) “n.”
- c. The following orthodontic services:
  - (1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8) “a.”
  - (2) Interceptiv orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “b.”
  - (3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “c.”
- d. The following restorative services:
  - (1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3) “d”(3).
  - (2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3) “d”(4).
- e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5) “d.”
- f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9) “g.”

**78.28(4)** 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(5)** 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(6)** Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

*a.* Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

*b.* All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

*c.* Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

**78.28(7)** 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 is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the department.

**78.28(8)** 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(9)** Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

**78.28(10)** 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(11)** Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) "b")

**78.28(12)** High-technology radiology procedures.

*a.* Except as provided in paragraph 78.28(12) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

*b.* Notwithstanding paragraph 78.28(12) "a," prior authorization is not required when any of the following applies:

- (1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;
- (2) The member has Medicare coverage;
- (3) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

*c.* Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

*d.* Required requests for prior approval of radiology procedures must be submitted to the department of human services.

*e.* When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-5595, Outpatient Prior Authorization Request, and approved before any claim for payment is submitted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

**441—78.29(249A) Behavioral health services.** Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

**78.29(1) Limitations.**

- a.* An assessment and a treatment plan are required.
- b.* Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

**78.29(2) Exclusions.** Payment will not be approved for the following services:

- a.* Services provided in a medical institution.
- b.* Services performed without relationship to a specific condition, risk factor, symptom, or complaint.
- c.* Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.
- d.* Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

**78.29(3) Payment.**

- a.* Payment shall be made only for time spent in face-to-face consultation with the member.
- b.* A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

**441—78.30(249A) Birth centers.** Payment will be made for prenatal, delivery, and postnatal services.

**78.30(1) Risk assessment.** Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

- a.* If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
- b.* If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

**78.30(2) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.31(249A) Hospital outpatient services.**

**78.31(1) Covered hospital outpatient services.** Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections

and appeals are acceptable sites. All outpatient services listed in paragraphs “g” to “m” are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs “a” to “f” shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs “g” to “m” shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a. Emergency service.
- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.
- e. Follow-up or after-care specialty clinics.
- f. Physical medicine and rehabilitation.
- g. Alcoholism and substance abuse.
- h. Eating disorders.
- i. Cardiac rehabilitation.
- j. Mental health.
- k. Pain management.
- l. Diabetic education.
- m. Pulmonary rehabilitation.
- n. Nutritional counseling for persons aged 20 and under.

**78.31(2) Requirements for all outpatient services.**

a. *Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. *Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. *Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. *Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. *Criteria for selection and continuing treatment of patients.* The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. *Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. *Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

*h. Vaccines.* In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**78.31(3) Application for certification.** Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

*a.* Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

*b.* Goals and objectives of the program.

*c.* Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

*d.* Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

*e.* Any accreditations or other types of approvals from national or state organizations.

*f.* The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

**78.31(4) Requirements for specific types of service.**

*a.* Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient’s dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

*b.* Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, Mallory-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; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—78.32(249A) Area education agencies.** Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.33(249A) Case management services.** Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—78.34(249A) HCBS health and disability waiver services.** Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.34(1) Homemaker services.** Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

*a.* Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

*b.* Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

*c.* Meal preparation: planning and preparing balanced meals.

**78.34(2) Home health services.** Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

*a.* Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

*b.* In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

*c.* Skilled nursing care is not covered.

**78.34(3) Adult day care services.** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.34(4) Nursing care services.** Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the

home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

**78.34(5) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

*a.* Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

*b.* Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

*c.* A unit of service is 15 minutes.

*d.* Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

*e.* The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

*f.* A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

*g.* Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

*h.* Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.34(6) Counseling services.** Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

**78.34(7) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.34(8) Interim medical monitoring and treatment services.** Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 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 in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; 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. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.
  - 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 unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

*d.* The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

**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 (CCO) 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. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13) "i." 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) 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.
- (3) 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.
- (4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability 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.
- (5) 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. Home and vehicle modification.
  3. Prevocational services.
  4. Basic individual respite care.
  5. Specialized medical equipment.
  6. Supported community living.
  7. Supported employment.
  8. Transportation.
- (6) 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.
- (7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13)“b”(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(8) 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.

(9) 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.

(10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) "b"(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) "b"(8).

(11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13) "b"(7) or the utilization adjustment factor in subparagraph 78.34(13) "b"(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member's need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member's service plan and authorized by the case manager or community-based case manager.

(12) 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 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 community-based case manager.

(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 community-based case manager.

(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.” At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. 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.
    23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.
    24. Residential services provided to three or more members living in the same residential setting.
  - (4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of

the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13)"b"(11).

(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 before the start of the savings plan by the department for fee-for-service members or by the member's managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.

(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.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. 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 allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. 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 community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(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 or managed care organization 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 for employees shall be consistent with employee reimbursement rates or the prevailing wages 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. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(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. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

- (1) Recruit and hire employees.
- (2) Verify employee qualifications.
- (3) Specify additional employee qualifications.
- (4) Determine employee duties.
- (5) Determine employee wages and benefits.
- (6) Schedule employees.
- (7) Train and supervise employees.

*i. Delegation of budget and employer authority.* The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h." Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

- (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 the responsibilities of the representative.
- (4) The representative shall not be paid for this service.

*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, at a minimum, 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) Monitor and track the approved individual budget amount authorized each month and document all 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.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

*m. Responsibilities of the member and the employee.* A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.

(4) Employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. Documentation shall comport with 441—subparagraph 79.3(2) "c"(3), "Service documentation."

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13) "m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

**78.34(14) General service standards.** All health and 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.* All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

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

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

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

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

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21]

**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, or a Medicare election of hospice benefit form, 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.  
[ARC 3553C, IAB 1/3/18, effective 2/7/18]

**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. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**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 unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

*d.* The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals

exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

**78.37(9) Home and vehicle modification.** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

*b.* Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

*c.* A unit of service is the completion of needed modifications or adaptations.

*d.* All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

*e.* Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

*f.* All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

*g.* Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

*h.* Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.37(10) *Mental health outreach.*** Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

**78.37(11) *Transportation.*** Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

**78.37(12) *Nutritional counseling.*** Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

**78.37(13) *Assistive devices.*** Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

*a.* The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

*b.* The service shall be provided following prior approval by the Iowa Medicaid enterprise.

*c.* Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.37(14) *Senior companion.*** Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

**78.37(15) *Consumer-directed attendant care service.*** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)“*f*” and the skilled activities listed in paragraph 78.37(15)“*g*.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.

(6) Housekeeping, laundry, and shopping essential to the member’s health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

**78.37(16) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**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—90.4(249A) through 441—90.7(249A).

*b.* Case management shall not include the provision of direct services by the case managers.

*c.* Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

**78.37(18) Assisted living service.** The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

- a. A unit of service is one day.
- b. A day of assisted living service is billable only if both the following requirements are met:
  - (1) The member was present in the facility during that day's bed census.
  - (2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

**78.37(19) General service standards.** All elderly waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
  - (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
  - (2) The need for the restriction.
  - (3) The less intrusive methods of meeting the need that have been tried but did not work.
  - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
  - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
  - (6) The informed consent of the member.
  - (7) An assurance that the interventions and supports will cause no harm to the member.
  - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
  - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
  - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
  - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
  - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.  
 [ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20]

**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. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and

work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**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 unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

**78.38(7) Adult day care services.** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.38(8) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) "f" and the skilled activities listed in paragraph 78.38(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.38(9) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**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.* All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

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

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

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

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

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**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. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.41(1) Supported community living services.** Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

*a.* Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and

prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

*b.* The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

*c.* Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

*d.* A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

*e.* Maintenance and room and board costs are not reimbursable.

*f.* Provider budgets shall reflect costs associated with members' specific support needs 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, 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 \$7,334.62 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 service activities provided pursuant to subrule 78.27(10).

**78.41(8) *Consumer-directed attendant care service.*** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8)“*f*” and the skilled activities listed in paragraph 78.41(8)“*g*.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“*b*,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
  - (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
  - (8) Colostomy care.
  - (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
  - (10) Postsurgical nursing care.
  - (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
  - (12) Preparing and monitoring response to therapeutic diets.
  - (13) Recording and reporting of changes in vital signs to the nurse or therapist.
- h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):
- (1) Any activity related to supervising a member. Only direct services are billable.
  - (2) Any activity that the member is able to perform.
  - (3) Costs of food.
  - (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
  - (5) Exercise that does not require skilled services.
  - (6) Parenting or child care for or on behalf of the member.
  - (7) Reminders and cueing.
  - (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
  - (9) Transportation costs.
  - (10) Wait times for any activity.

**78.41(9) Interim medical monitoring and treatment services.** Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 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 in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

**78.41(10)** *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

*e.* The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“*d.*”

*f.* Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

*g.* A unit of service is a day.

*h.* The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

**78.41(11) *Transportation.*** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

**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), or a full day (4.25 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 service activities provided pursuant to subrule 78.27(9).

**78.41(14) *Day habilitation.*** Day habilitation services will be provided pursuant to subrule 78.27(8).

**78.41(15) *Consumer choices option.*** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**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.* All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

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

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

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

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

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21]

**441—78.42(249A) Pharmacists providing covered vaccines.** When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

**78.42(1) Vaccines administered to children.** Payment will be made to an enrolled provider for an administration fee for vaccines available through the Vaccines for Children (VFC) program administered by the department of public health if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

**78.42(2) Vaccines administered to adults.** Payment will be made to an enrolled provider for an administration fee and vaccine cost.

**78.42(3) Verification and reporting.** Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient's primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 5175C, IAB 9/9/20, effective 6/1/21]

**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. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**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—90.4(249A) through 441—90.7(249A).

*b.* The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

*c.* The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

*d.* Members who are eligible for targeted case management are not eligible for case management as a waiver service.

**78.43(2) Supported community living services.** Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

*a.* The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

*b.* The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

*c.* Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

*d.* A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

*e.* Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2) "e"(1) does not apply.

*f.* The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

*g.* The service shall be identified in the member's service plan.

*h.* Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

**78.43(3) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

*a.* Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

*b.* Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

*c.* A unit of service is 15 minutes.

*d.* Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

*e.* The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

*f.* A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

*g.* Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

*h.* Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

**78.43(4)** *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

**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.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.43(6) Personal emergency response or portable locator system.**

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.43(7) Transportation.** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

**78.43(8) Specialized medical equipment.**

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 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 service activities provided pursuant to subrule 78.27(9).

**78.43(12) *Behavioral programming.*** Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

**78.43(13) *Consumer-directed attendant care service.*** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13) "f" and the skilled activities listed in paragraph 78.43(13) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.43(14) Interim medical monitoring and treatment services.** Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 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 in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; 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 is service activities provided pursuant to subrule 78.34(13).

**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. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

- (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d.* Services must be billed in whole units.
- e.* For all services with a 15-minute unit of service, the following rounding process will apply:
  - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
  - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
  - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
  - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4897C**, IAB 2/12/20, effective 3/18/20; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

**441—78.44(249A) Lead inspection services.** Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.45(249A) Assertive community treatment.** Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

**78.45(1) Applicability.** ACT services may be provided only to a member who meets all of the following criteria:

- a.* The member is at least 17 years old.
- b.* The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:
  - (1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;
  - (2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and
  - (3) The member exhibits significant impairment in social, interpersonal, or familial functioning.
- c.* The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental

Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

*d.* The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

*e.* The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

*f.* At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

*g.* The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

**78.45(2) Services.** The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

*a. Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

*b. Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

*c. Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

*d. Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced

registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

*e. Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

*f. Case management for treatment and service plan coordination.* Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

*g. Crisis response.* Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

*h. Work-related services.* Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

**441—78.46(249A) Physical disability waiver service.** Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and

work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.46(1) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) “f” and the skilled activities listed in paragraph 78.46(1) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

**78.46(2) Home and vehicle modification.** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

*b.* Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

*c.* A unit of service is the completion of needed modifications or adaptations.

*d.* All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

*e.* Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

*f.* All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

*g.* Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

*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 \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

*d.* The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

*e.* Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.46(5) *Transportation.*** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

**78.46(6) *Consumer choices option.*** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**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.* All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

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

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

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

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

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**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. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**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. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. 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 Medicaid 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; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

**441—78.53(249A) Health home services.** Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

**78.53(1) *Covered services.*** Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

- a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

*b.* Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

*c.* Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

(2) Improving disease control; and

(3) Enhancing safety, disease prevention, and an overall healthy lifestyle.

*d.* Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:

(1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and

(2) Personal follow-up with the member regarding all needed follow-up after the transition.

*e.* Member and family support (including authorized representatives). This support may include:

(1) Communicating with and advocating for the member or family for the assessment of care decisions;

(2) Assisting with obtaining and adhering to medications and other prescribed treatments;

(3) Increasing health literacy and self-management skills; and

(4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

*f.* Referral to community and social support services available in the community.

**78.53(2)** *Members eligible for health home services.*

*a.* Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

(1) Has at least two chronic conditions;

(2) Has one chronic condition and is at risk of having a second chronic condition;

(3) Has a serious mental illness; or

(4) Has a serious emotional disturbance.

*b.* For purposes of this rule, the term "chronic condition" means:

(1) A mental health disorder.

(2) A substance use disorder.

(3) Asthma.

(4) Diabetes.

(5) Heart disease.

(6) Being overweight, as evidenced by:

1. Having a body mass index (BMI) over 25 for an adult, or

2. Weighing over the 85th percentile for the pediatric population.

(7) Hypertension.

*c.* For purposes of this rule, the term "serious mental illness" means:

(1) A psychotic disorder;

(2) Schizophrenia;

(3) Schizoaffective disorder;

- (4) Major depression;
- (5) Bipolar disorder;
- (6) Delusional disorder; or
- (7) Obsessive-compulsive disorder.

*d.* For purposes of this rule, the term “serious emotional disturbance” means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term “functional impairment” means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person’s role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person’s environment.

**78.53(3) Selection of health home services provider.** As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member’s health home, as reported by the provider. A member must select a provider located in the member’s county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

**441—78.54(249A) Speech-language pathology services.** Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

**441—78.55(249A) Services rendered via telehealth.** An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).

[ARC 2166C, IAB 9/30/15, effective 11/4/15]

**441—78.56(249A) Community-based neurobehavioral rehabilitation services.** Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

**78.56(1) Definitions.**

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Brain injury*” means a diagnosis in accordance with rule 441—83.81(249A).

“*Health care*” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“*Intermittent community-based neurobehavioral rehabilitation services*” are provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member’s own home and community.

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

“*Neurobehavioral rehabilitation*” refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member’s independence in activities of daily living and ability to live in the member’s home and community.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

“*Standardized assessment*” means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member’s individual needs.

**78.56(2) Member eligibility.** To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. *Brain injury diagnosis.* To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. *Risk factors.* The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. *Need for assistance.* The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. *Needs assessment.* The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a qualified trained assessor. The assessment of need shall document the member’s need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member’s managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. *Standards for assessment.* Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member’s individual physical, emotional, cognitive, medical and psychosocial residuals related to the member’s brain injury and must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member’s ability to self-manage the member’s symptoms.

(3) The member’s rehabilitation and medical care history to include medication history and status.

(4) The member’s employment history and the member’s barriers to employment.

(5) The member’s dietary and nutritional needs.

(6) The member’s community accessibility and safety.

(7) The member’s access to transportation.

(8) The member’s history of substance abuse.

(9) The member’s vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

*f. Emergency admission.* In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

**78.56(3) Covered services.**

*a. Service setting.*

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

*b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:*

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLS (activities of daily living);

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

(8) Health and wellness management including dietary and nutritional programming;

(9) Progressive physical strengthening, fitness and retraining;

(10) Assistance with obtaining and use of assistive technology;

(11) Sobriety support development;

(12) Assistance with the self-identification of antecedent triggers;

(13) Assistance with preparation for transition to less intensive services including accessing the community;

(14) Flexibility in programming to meet individual needs;

(15) Assistance with re-learning coping and compensatory strategies;

(16) Support and assistance in seeking substance abuse and co-occurring disorders services;

(17) Support and assistance with obtaining legal consultation and services;

(18) Assistance with community accessibility and safety;

(19) Assistance with re-learning household maintenance;

(20) Assistance with recreational and leisure skill development;

(21) Assistance with the development and application of self-advocacy skills to navigate the service system;

(22) Opportunities to learn about brain injury and individual needs following brain injury;

(23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(24) Assistance with pursuit of education and employment goals;

(25) Protective oversight in the residential setting and community;

(26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;

(27) Transitional support and training;

(28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;

(29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

*c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:*

- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (4) Behavioral supports;
- (5) Assistance with obtaining and use of assistive technology;
- (6) Assistance with the self-identification of antecedent triggers;
- (7) Flexibility in programming to meet the member's individual needs;
- (8) Assistance with re-learning coping and compensatory strategies;
- (9) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;
- (12) Transitional support and training;
- (13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

*d.* Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

*e.* Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

- (1) The IME medical services unit will approve the provider's treatment plan if:
  1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);
  2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;
  3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
  4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and
  5. The treatment plan does not exceed 180 days in duration.
- (2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

*f.* Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

- g.* Quality review. The IME medical services unit may perform the quality review to evaluate:
- (1) The time elapsed from referral to rehabilitation treatment plan development;
  - (2) The continuity of treatment;
  - (3) The length of stay per member;
  - (4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;
  - (5) Gaps in service;
  - (6) The results achieved;
  - (7) Member and stakeholder satisfaction;
  - (8) The provider's compliance with standards listed in rule 441—77.54(249A).

**78.56(4) Medical necessity.** Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

- a.* Consistent with the diagnosis and treatment of the member's condition;

- b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c. The least costly type of service that can reasonably meet the medical needs of the member; and
- d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:
  - (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
  - (2) The professional literature regarding best practices in the field.

**78.56(5) Documentation standards.** Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20]

**441—78.57(249A) Child care medical services.** Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

**78.57(1) Nursing services** are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

**78.57(2) Personal care services** are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

**78.57(3) Psychosocial services** are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

**78.57(4) Developmental therapies** are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

**78.57(5) "Medically necessary"** means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

**78.57(6) Requirements.**

- a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
- (2) Type of service to be rendered and the treatment modalities being used.
- (3) Frequency of the services.
- (4) Assistance devices to be used.
- (5) Date on which services were initiated.
- (6) Progress of member in response to treatment.
- (7) Medical supplies to be furnished.
- (8) Member's medical condition as reflected by the following information, if applicable:
  1. Dates of prior hospitalization.
  2. Dates of prior surgery.
  3. Date last seen by a primary care provider.
  4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
  5. Prognosis.
  6. Functional limitations.
  7. Vital signs reading.
  8. Date of last episode of acute recurrence of illness or symptoms.
  9. Medications.
- (9) Discipline of the person providing the service.
- (10) Certification period.
- (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
- (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.

**78.57(7)** Nursing, personal care, and psychosocial services do not include:

- a. Services provided to members aged 21 and older.
- b. Services that require prior authorizations that are provided without regard to the prior authorization process.
- c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
- d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
- e. Transportation services.
- f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

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

**441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.**

**78.58(1) Payment.** Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

**78.58(2) Definitions.**

“Coinsurance” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicare cost sharing*” means the Medicare member’s responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

**441—78.59(249A) Health insurance premium payment (HIPP) provider services.**

**78.59(1) Reimbursement.** A HIPP provider may bill the department for the HIPP-eligible member’s out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member’s health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

**78.59(2) Definitions.**

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Cost sharing*” means the member’s health insurance in-network responsibility for a covered service. “Cost sharing” includes coinsurance, copayments, and deductibles.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Eligible member*” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department’s HIPP program prescribed under rule 441—75.21(249A).

“*Health insurance premium payment (HIPP) program*” or “*HIPP program*” has the same meaning as provided in rule 441—75.21(249A).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

**441—78.60(249A) Crisis response services.** Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

**441—78.61(249A) Subacute mental health services.** Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

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- 1 Two ARCs
- 2 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.
- 3 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.
- 4 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.
- 5 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.
- 6 Two ARCs
- 7 Two ARCs
- 8 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**.
- 9 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
- 10 Two or more ARCs
- 11 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.
- 12 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.
- 13 July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- 14 March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.

CHAPTER 83  
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

[ARC 2471C, IAB 3/30/16, effective 5/4/16]

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

**441—83.1(249A) Definitions.**

*“Attorney in fact under a durable power of attorney for health care”* means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

*“Basic individual respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

*“Blind individual”* means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

*“Client participation”* means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

*“Deeming”* means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

*“Disabled person”* means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

*“Financial participation”* means client participation and medical payments from a third party including veterans’ aid and attendance.

*“Group respite”* is respite provided on a staff-to-consumer ratio of less than one to one.

*“Guardian”* means a guardian appointed in probate court.

*“Intermediate care facility for persons with an intellectual disability level of care”* means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Intermittent homemaker service”* means homemaker service provided from one to three hours a day for not more than four days per week.

*“Intermittent respite service”* means respite service provided from one to three times a week.

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

*“Medical assessment”* means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

*“Medical institution”* means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

*“Medical intervention”* means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

*“Medical monitoring”* means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*“Service plan”* means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

*“Skilled nursing facility level of care”* means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
  - a. A physician order for all skilled services.
  - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
  - c. An individualized care plan that identifies support needs.
  - d. Confirmation that skilled services are provided to the member.
  - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
  - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

*“Specialized respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

*“Substantial gainful activity”* means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

*“Third-party payments”* means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

*“Usual caregiver”* means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—83.2(249A) Eligibility.** To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

**83.2(1) Eligibility criteria.**

*a.* The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

*b.* Rescinded IAB 1/2/19, effective 2/6/19.

*c.* Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

*d.* The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available upon request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in 441—paragraph 90.4(1) "b."

(2) The IME medical services unit shall be responsible for the initial determination of the member's level of care certification. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

*e.* To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician or a physician assistant.

*f.* The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) "b" and 75.5(4) "c" shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

**83.2(2) Need for services.**

a. The member shall have a service plan approved by the department which is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1)“d” and other supporting documentation as relevant. The designated case manager shall have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,792.65	\$959.50	\$3,742.93

For members enrolled in the health and disability waiver in accordance with subrule 83.2(1), when a member turns 21 years of age, the average monthly cost of services received through 441—subrule 78.9(10) (state plan private duty nursing or personal care services for persons aged 20 and under) shall be used to increase the monthly waiver budget in accordance with the following:

(1) The member must request the revised waiver budget through the member's case manager no earlier than two months before, and no later than six months after, the member's twenty-first birthday. A renewal request must be received annually no earlier than two months before, and no later than six months after, each subsequent birthday.

(2) The member's waiver budget shall be increased by the average monthly cost of state plan private duty nursing or personal care services for the member that was billed to and paid by Iowa Medicaid or an Iowa Medicaid-contracted managed care organization during the year in which the member is 20 years of age.

(3) Once the request is received by the department, the department shall determine the average monthly cost pursuant to the claims data available at the time of the request. No subsequent claims data shall be considered.

(4) The revised waiver budget reflecting the average cost of state plan private duty nursing or personal care services shall become effective on the later of the first day of the month of the member's twenty-first birthday or the first day of the month of the completed review.

(5) The revised waiver budget shall extend up to the first of the month following the member's twenty-fifth birthday and shall remain at the initially authorized amount for the member while aged 21 through 24.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4209C, IAB 1/2/19, effective 2/6/19; ARC 4897C, IAB 2/12/20, effective 3/18/20]

#### **441—83.3(249A) Application.**

**83.3(1)** *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.3(2)** *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant’s name shall be placed on a waiting list maintained by the bureau of long-term care.

*a.* The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

*b.* If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)“a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

**83.3(3) Approval of application.**

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to the IME medical services unit.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

**83.3(4) Effective date of eligibility.**

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4)“a” and “c” do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1) “c”(3) shall exist on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.3(5) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.4(249A) Financial participation.** Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

**83.4(1) Maintenance needs of the individual.** The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client’s total income.

**83.4(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

**83.4(3) Maintenance needs of spouse and other dependents.** Rescinded IAB 4/9/97, effective 6/1/97. [ARC 0757C, IAB 5/29/13, effective 8/1/13]

**441—83.5(249A) Redetermination.** A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person’s situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

**83.5(1)** The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

**83.5(2)** The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—83.6(249A) Allowable services.** Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

**441—83.7(249A) Service plan.** A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.4(1) “b.” Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person’s situation or condition.

**83.7(1)** The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

**83.7(2)** The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

**83.7(3)** The service plan shall also list all nonwaiver Medicaid services.

**83.7(4)** The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4897C, IAB 2/12/20, effective 3/18/20]

**441—83.8(249A) Adverse service actions.**

**83.8(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the aggregate monthly costs established in 83.2(2) “b,” or are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.

**83.8(2) Termination.** A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) “b.”
- c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.
- d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the designated case manager.
- e. Service providers are not available.

**83.8(3)** Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.9(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

**441—83.10(249A) County reimbursement.** Rescinded IAB 4/9/97, effective 6/1/97.

**441—83.11(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.12 to 83.20** Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

**441—83.21(249A) Definitions.**

*“Attorney in fact under a durable power of attorney for health care”* means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

*“Basic individual respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

*“Client participation”* means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

*“Group respite”* is respite provided on a staff-to-consumer ratio of less than one to one.

*“Guardian”* means a guardian appointed in probate court.

*“Interdisciplinary team”* means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

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

*“Medical institution”* means a nursing facility which has been approved as a Medicaid vendor.

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*“Service plan”* means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

*“Skilled nursing facility level of care”* means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

*“Specialized respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

*“Third-party payments”* means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.  
 [ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—83.22(249A) Eligibility.** To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

**83.22(1) Eligibility criteria.** All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.  
 b. A resident of the state of Iowa.  
 c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)“b” and 75.5(4)“c” shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - Home Care (HC) is available on request from IME medical services unit and other supporting documentation as relevant. Copies of the completed interRAI - Home Care (HC) for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

(2) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

**83.22(2) Need for services, service plan, and cost.**

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to rule 441—77.29(249A). Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer’s legal representative, family, service providers, and others directly involved in the consumer’s care.

(2) *Role.* The team shall identify:

1. The consumer’s need for services based on the consumer’s needs and desires.

2. Available and appropriate services to meet the consumer’s needs.

3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer’s needs change.

c. *Service plan.* An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member.

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

*d. Content of service plan.* The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.

2. The funding source for the service.

3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.

2. The emergency backup support and crisis response system identified by the interdisciplinary team.

3. Emergency, backup staff designated by providers for applicable services.

**83.22(3) Providers—standards.** Rescinded IAB 10/11/06, effective 10/1/06.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5419C, IAB 2/10/21, effective 4/1/21]

#### **441—83.23(249A) Application.**

**83.23(1) Application for HCBS elderly waiver.** The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.23(2) Application for services.** Rescinded IAB 12/6/95, effective 2/1/96.

**83.23(3) Approval of application.**

*a.* Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

*b.* Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in 83.22(1) “d,” indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

**83.23(4) Effective date of eligibility.**

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.23(5) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.24(249A) Client participation.** Persons must contribute their predetermined client participation to the cost of elderly waiver services.

**83.24(1) Computation of client participation.** Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client’s total income.

**83.24(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

**441—83.25(249A) Redetermination.** A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

**83.25(1)** The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

**83.25(2)** The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

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

**441—83.26(249A) Allowable services.** Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach,

transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

**441—83.27(249A) Service plan.** The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

**83.27(1)** The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

**83.27(2)** The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

**441—83.28(249A) Adverse service actions.**

**83.28(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs are not met by services provided.
- d. Needed services are not available or received from qualifying providers.
- e. Rescinded IAB 3/2/94, effective 3/1/94.

**83.28(2) Termination.** A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes other than respite care.
- c. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.
- d. Service providers are not available.

**83.28(3)** Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”  
[ARC 3234C, IAB 8/2/17, effective 9/6/17; ARC 5419C, IAB 2/10/21, effective 4/1/21]

**441—83.29(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

**441—83.30(249A) Enhanced services.** When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services shall be used.

**441—83.31(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.32 to 83.40** Reserved.

#### DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

**441—83.41(249A) Definitions.**

“AIDS” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

*“Attorney in fact under a durable power of attorney for health care”* means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

*“Basic individual respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

*“Client participation”* means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

*“Deeming”* means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

*“Financial participation”* means client participation and medical payments from a third party including veterans’ aid and attendance.

*“Group respite”* is respite provided on a staff-to-consumer ratio of less than one to one.

*“Guardian”* means a guardian appointed in probate court.

*“HIV”* means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

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

*“Medical institution”* means a nursing facility or hospital which has been approved as a Medicaid vendor.

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*“Service plan”* means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

*“Skilled nursing facility level of care”* means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
  - a. A physician order for all skilled services.
  - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
  - c. An individualized care plan that identifies support needs.
  - d. Confirmation that skilled services are provided to the member.
  - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
  - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—83.42(249A) Eligibility.** To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

**83.42(1) Eligibility criteria.** All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment as listed in 83.42(1)“b” shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

**83.42(2) Need for services.**

a. The designated case manager shall review the assessment of the person’s need for waiver services and determine the availability and appropriateness of services. This review shall be based, in part, on information in the completed information submission tool designated in 83.42(1)“b” and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$1,876.80.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

**441—83.43(249A) Application.**

**83.43(1)** *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.43(2)** *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

**83.43(3)** *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

**83.43(4)** *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

**83.43(5)** *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.44(249A) Financial participation.** Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

**83.44(1) *Maintenance needs of the individual.*** The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

**83.44(2) *Limitation on payment.*** If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

**83.44(3) *Maintenance needs of spouse and other dependents.*** Rescinded IAB 4/9/97, effective 6/1/97.

**441—83.45(249A) Redetermination.** A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

**83.45(1)** The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

**83.45(2)** The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

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

**441—83.46(249A) Allowable services.** Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

**441—83.47(249A) Service plan.** A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

**83.47(1)** The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

**83.47(2)** The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

**83.47(3)** Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

**83.47(4)** The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

**441—83.48(249A) Adverse service actions.**

**83.48(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.42(2) "b" or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

**83.48(2)** Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) “b.”
- c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.
- d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the service worker.
- e. Service providers are not available.

**83.48(3)** Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”  
[ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.49(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).  
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

**441—83.50(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.  
These rules are intended to implement Iowa Code section 249A.4.

**441—83.51 to 83.59** Reserved.

#### DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

**441—83.60(249A) Definitions.**

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with an intellectual disability aged 17 or under.

“*Client participation*” means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“*Counseling*” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

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

*“Direct service”* means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

*“Fiscal accountability”* means the development and maintenance of budgets and independent fiscal review.

*“Group respite”* is respite provided on a staff-to-consumer ratio of less than one to one.

*“Guardian”* means a guardian appointed in probate court.

*“Health”* means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

*“Immediate jeopardy”* means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

*“Intellectual disability”* means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

*“Intermediate care facility for persons with an intellectual disability (ICF/ID)”* means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

*“Intermediate care facility for persons with an intellectual disability level of care”* means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Intermittent supported community living service”* means supported community living service provided not more than 52 hours per month.

*“Maintenance needs”* means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

*“Managed care”* means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

*“Medical assessment”* means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

*“Medical institution”* means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

*“Medical intervention”* means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

*“Medical monitoring”* means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

*“Natural supports”* means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

*“Organization”* means the entity being certified.

*“Organizational outcome”* means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

*“Outcome”* means an action or event that follows as a result or consequence of the provision of a service or support.

*“Procedures”* means the steps to be taken to implement a policy.

*“Process”* means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

*“Qualified intellectual disability professional”* means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

*“Related condition”* means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*SIS assessment*” means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—83.61(249A) Eligibility.** To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

**83.61(1) Eligibility criteria.** All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

*b.* Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

*c.* Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

*d.* Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

*e.* Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

*f.* Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

*g.* For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

*h.* For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

*i.* For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

*j.* Choose HCBS intellectual disability waiver services rather than ICF/ID services.

*k.* To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical

emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

- (3) Residing in the consumer's family home or foster family home; and
- (4) In need of interim medical monitoring and treatment as ordered by a physician.

*l.* Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

*m.* For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

- 1. Social history;
- 2. Case history that includes previous placements and service programs;
- 3. Medical history that includes major illnesses and current medications;
- 4. Current psychological evaluations and consultations;
- 5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
- 6. Any current court orders in effect regarding the child;
- 7. Any legal history;
- 8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;
- 9. Whether the proposed placement would be safe for the child and for other children living in that setting; and
- 10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)"a"; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

*n.* For day habilitation, be 16 years of age or older.

*o.* For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

**83.61(2) Need for services.**

*a.* Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment.

*b.* Applicants not receiving services as set forth in paragraph 83.61(2)"a" shall have a department service worker or case manager:

(1) Arrange for completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

*c.* Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

*d.* Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of Form 470-4694 for children under the age of five and, for all others, to arrange a SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager's control.

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent Form 470-4694 for children under the age of five and, for all others, the SIS assessment or of the SIS contractor's off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

**83.61(3) HCBS intellectual disability waiver program limit.** The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

*b.* When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

**83.61(4) Securing a payment slot.** The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

*a.* A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

*b.* If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) "b"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) "b"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

*c.* To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

#### **441—83.62(249A) Application.**

**83.62(1)** *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**83.62(2)** Rescinded IAB 6/5/96, effective 8/1/96.

**83.62(3)** *Approval of application.*

*a.* Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

*b.* Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

*c.* An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer's choice of care.

*d.* HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

*e.* Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

*f.* HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

*g.* Rescinded IAB 5/6/09, effective 7/1/09.

**83.62(4)** *Effective date of eligibility.*

*a.* Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

*b.* The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

*c.* The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

*d.* Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 120 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid

coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

*e.* Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

**83.62(5) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.63(249A) Client participation.** Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

**83.63(1) Computation of client participation.** Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

**83.63(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

**441—83.64(249A) Redetermination.** A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which a SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. Form 470-4694 shall be completed annually for children under the age of five.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

**83.64(1)** The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

**83.64(2)** The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

**441—83.65(249A)** Rescinded IAB 6/5/96, effective 8/1/96.

**441—83.66(249A) Allowable services.** Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

**441—83.67(249A) Service plan.** A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

**83.67(1) Development.** The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

**83.67(2) Retention.** The service plan shall be stored by the case manager for a minimum of three years.

**83.67(3) Interdisciplinary team meeting.** The interdisciplinary team meeting shall be conducted before the current service plan expires.

**83.67(4) Information in plan.** The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
  - (1) The consumer's living environment at the time of waiver enrollment.
  - (2) The number of hours per day of on-site staff supervision needed by the consumer.
  - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
  - (1) Maintenance of personal funds.
  - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
  - (1) The independent support broker selected by the consumer; and
  - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

i. For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:

- (1) Score on subsection 1A: Exceptional Medical Support Needs.
- (2) Score on subsection 1B: Exceptional Behavioral Support Needs.
- (3) Sum total of standard scores on the following subsections:
  - 1. Subsection 2A: Home Living Activities;
  - 2. Subsection 2B: Community Living Activities;
  - 3. Subsection 2E: Health and Safety Activities; and
  - 4. Subsection 2F: Social Activities.

**83.67(5) Documentation.** The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

**83.67(6) Approval of plan.** The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18]

**441—83.68(249A) Adverse service actions.**

**83.68(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.
- g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

**83.68(2) Reduction.** A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

**83.68(3) Termination.** A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2) paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.
- g. The consumer receives services from other Medicaid waiver programs.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

**441—83.69(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

**441—83.70(249A) County reimbursement.** Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

**441—83.71(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

**441—83.72(249A) Rent subsidy program.** Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.73 to 83.80** Reserved.

#### DIVISION V—BRAIN INJURY WAIVER SERVICES

**441—83.81(249A) Definitions.**

“*Adaptive*” means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a brain injury aged 18 years or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

*“Assessment”* means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

*“Attorney in fact under a durable power of attorney for health care”* means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

*“Basic individual respite”* means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

*“Behavior”* means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

*“Brain injury”* means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum.
- Malignant neoplasms of brain, frontal lobe.
- Malignant neoplasms of brain, temporal lobe.
- Malignant neoplasms of brain, parietal lobe.
- Malignant neoplasms of brain, occipital lobe.
- Malignant neoplasms of brain, ventricles.
- Malignant neoplasms of brain, cerebellum.
- Malignant neoplasms of brain, brain stem.
- Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
- Malignant neoplasms of brain, cerebral meninges.
- Malignant neoplasms of brain, cranial nerves.
- Secondary malignant neoplasm of brain.
- Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
- Benign neoplasm of brain and other parts of the nervous system, brain.
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
- Encephalitis, myelitis and encephalomyelitis.
- Intracranial and intraspinal abscess.
- Anoxic brain damage.
- Subarachnoid hemorrhage.
- Intracerebral hemorrhage.
- Other and unspecified intracranial hemorrhage.
- Occlusion and stenosis of precerebral arteries.
- Occlusion of cerebral arteries.
- Transient cerebral ischemia.
- Acute, but ill-defined, cerebrovascular disease.
- Other and ill-defined cerebrovascular diseases.
- Fracture of vault of skull.
- Fracture of base of skull.
- Other and unqualified skull fractures.
- Multiple fractures involving skull or face with other bones.
- Concussion.
- Cerebral laceration and contusion.
- Cerebral edema.
- Cerebral palsy.

Subarachnoid, subdural, and extradural hemorrhage following injury.

Other and unspecified intracranial hemorrhage following injury.

Intracranial injury of other and unspecified nature.

Poisoning by drugs, medicinal and biological substances.

Toxic effects of substances.

Effects of external causes.

Drowning and nonfatal submersion.

Asphyxiation and strangulation.

Child maltreatment syndrome.

Adult maltreatment syndrome.

Status epilepticus.

*“Case management services”* means those services established pursuant to Iowa Code chapter 225C.

*“Child”* means a person with a brain injury aged 17 years or under.

*“Client participation”* means the amount of the consumer’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

*“Deemed status”* means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

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

*“Direct service”* means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

*“Fiscal accountability”* means the development and maintenance of budgets and independent fiscal review.

*“Group respite”* is respite provided on a staff-to-consumer ratio of less than one to one.

*“Guardian”* means a guardian appointed in probate court.

*“Health”* means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

*“Immediate jeopardy”* means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

*“Intermediate care facility for persons with an intellectual disability level of care”* means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

*“Intermittent supported community living service”* means supported community living service provided from one to three hours a day for not more than four days a week.

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

*“Medical assessment”* means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

*“Medical institution”* means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

*“Medical intervention”* means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

*“Medical monitoring”* means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

*“Natural supports”* means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*“Organization”* means the entity being certified.

*“Organizational outcome”* means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

*“Outcome”* means an action or event that follows as a result or consequence of the provision of a service or support.

*“Procedures”* means the steps to be taken to implement a policy.

*“Process”* means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

*“Qualified brain injury professional”* means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

*“Service coordination”* means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

*“Service plan”* means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

*“Skilled nursing facility level of care”* means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.

- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

- c. An individualized care plan that identifies support needs.

- d. Confirmation that skilled services are provided to the member.

- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4792C, IAB 12/4/19, effective 1/8/20]

**441—83.82(249A) Eligibility.** To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

**83.82(1) Eligibility criteria.** All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be at least one month of age.
- d. Be a U.S. citizen and Iowa resident.
- e. Rescinded IAB 7/11/01, effective 7/1/01.
- f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC), Form 470-4694, and Form 470-5572, the Mayo-Portland Adaptability Inventory (MPAI), are available on request from the member’s managed care organization or the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.
- g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.
- j. To be eligible for interim medical monitoring and treatment services the consumer must be:
  - (1) Under the age of 21;
  - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
  - (3) Residing in the consumer’s family home or foster family home; and
  - (4) In need of interim medical monitoring and treatment as ordered by a physician.
- k. Receive services in a community, not an institutional, setting.
- l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.
- m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.
- n. For individual supported employment and long-term job coaching services:

- (1) Be at least 16 years of age.
- (2) The services must not be available to the member through one of the following:
  1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
  2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
- (3) Not reside in a medical institution.
- (4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.
  - o.* For small-group supported employment services:
    - (1) Be at least 16 years of age.
    - (2) The services must not be available to the member through one of the following:
      1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
      2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
    - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
    - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
  - (5) Not reside in a medical institution.
  - p.* For prevocational services:
    - (1) Be at least 16 years of age.
    - (2) The services must not be available to the member through one of the following:
      1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
      2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
    - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.
    - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

**83.82(2) *Need for services.***

*a.* The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

*b.* Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person’s needs as a precondition of eligibility for the HCBS BI waiver.

**83.82(3)** *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

**83.82(4)** *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an intermediate care facility for persons with an intellectual disability (ICF/ID), a skilled nursing facility, or an ICF and have resided in that setting for six or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants shall be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants shall be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots shall have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons shall be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

*e.* The department shall reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state on July 1, 2019, and for all new applications received on or after July 1, 2019. Applicants may request an emergency need reserved capacity slot by submitting the completed Home- and Community-Based Services (HCBS) Brain Injury Waiver Emergency Need Assessment, Form 470-5583, to the IME medical services unit.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter, and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(4) "e"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.82(4) "e"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall remain on the waiting list, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new emergency needs assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

*f.* To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 4974C, IAB 3/11/20, effective 4/15/20]

#### **441—83.83(249A) Application.**

**83.83(1)** *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

##### **83.83(2)** *Approval of application for eligibility.*

*a.* Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

*b.* Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

*c.* An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall sign the applicable information submission tool listed in paragraph 83.82(1) "*f*," indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

*d.* The medical facility discharge planner, if there is one involved, shall contact the consumer's managed care organization or the designated case manager to initiate development of the consumer's service plan and initiation of waiver services.

*e.* HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

*f.* HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

*g.* The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

##### **83.83(3)** *Effective date of eligibility.*

*a.* The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

*b.* The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

*c.* Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.83(4) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.84(249A) Client participation.** Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

**83.84(1) Computation of client participation.** Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

**83.84(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

**441—83.85(249A) Redetermination.** A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

**441—83.86(249A) Allowable services.** Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

**441—83.87(249A) Service plan.** A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

**83.87(1) Information in plan.** The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
  - (1) The consumer's living environment at the time of waiver enrollment.
  - (2) The number of hours per day of on-site staff supervision needed by the consumer.
  - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
  - (1) Maintenance of personal funds.
  - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
  - (1) The independent support broker selected by the consumer; and
  - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

**83.87(2) Use of nonwaiver services.** Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

**83.87(3) Annual assessment.** The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1) "f" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

**83.87(4) Service file.** The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to d. Rescinded IAB 8/7/02, effective 10/1/02.  
 [ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

#### **441—83.88(249A) Adverse service actions.**

**83.88(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The brain injury waiver service is not identified in the consumer's service plan.

*f.* There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

*g.* The consumer receives services from other Medicaid waiver providers.

*h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

**83.88(2) Reduction.** A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

**83.88(3) Termination.** A particular service may be terminated when the department determines that:

*a.* The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.

*b.* Needed services are not available or received from qualifying providers.

*c.* The brain injury waiver service is not identified in the consumer's annual service plan.

*d.* Service needs are not met by the services provided.

*e.* Services needed exceed the service unit or reimbursement maximums.

*f.* Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.

*g.* The consumer receives services from other Medicaid providers.

*h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

**441—83.89(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

**441—83.90(249A) County reimbursement.** Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

**441—83.91(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.  
These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.92 to 83.100** Reserved.

#### DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

**441—83.101(249A) Definitions.**

“*Adaptive*” means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a physical disability aged 18 years to 64 years.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Behavior*” means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Client participation*” means the amount of the consumer's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

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

*“Guardian”* means a guardian appointed in probate court for an adult.

*“Intermediate care facility for persons with an intellectual disability level of care”* means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

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

*“Medical institution”* means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

*“Nursing facility level of care”* means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

*“Physical disability”* means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

*“Service plan”* means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

*“Skilled nursing facility level of care”* means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

*“Third-party payments”* means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

*“Waiver year”* means a 12-month period commencing on April 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—83.102(249A) Eligibility.** To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

**83.102(1) Eligibility criteria.** All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(2) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

**83.102(2) Need for services.**

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager shall identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in 83.102(1)“h,” as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed \$705.84 per month.

**83.102(3) Slots.** The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

**83.102(4) County payment slots for persons requiring the ICF/MR level of care.** Rescinded IAB 10/6/99, effective 10/1/99.

**83.102(5) Securing a slot.**

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

*b.* If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

**83.102(6)** *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

**83.102(7)** *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

#### **441—83.103(249A) Application.**

**83.103(1)** *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

**83.103(2)** *Approval of application for eligibility.*

*a.* Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall contact the member's managed care organization or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h."

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

*b.* Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's managed care organization or the designated case manager shall arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h" and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

**83.103(3) Effective date of eligibility.**

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

**83.103(4) Attribution of resources.** For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.104(249A) Client participation.** Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

**83.104(1) Computation of client participation.** Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

**83.104(2) Limitation on payment.** If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

**441—83.105(249A) Redetermination.** A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

**441—83.106(249A) Allowable services.** The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

**441—83.107(249A) Individual service plan.** An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer, the consumer's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

**83.107(1) Information in plan.** The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
  - (1) The independent support broker selected by the consumer; and
  - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

**83.107(2) Annual assessment.** The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1) "h" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

**83.107(3) Case file.** Rescinded IAB 8/7/02, effective 10/1/02.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

**441—83.108(249A) Adverse service actions.**

**83.108(1) Denial.** An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer's service plan.

*f.* There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

*g.* The consumer receives services from other Medicaid waiver providers.

*h.* The consumer or legal representative requests termination from the services.

**83.108(2) Reduction.** A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

**83.108(3) Termination.** A particular service may be terminated when the department determines that:

*a.* The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.

*b.* Needed services are not available or received from qualifying providers.

*c.* The physical disability waiver service is not identified in the consumer's annual service plan.

*d.* Service needs are not met by the services provided.

*e.* Services needed exceed the service unit or reimbursement maximums.

*f.* Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.

*g.* The consumer receives services from other Medicaid providers.

*h.* The consumer or legal representative requests termination from the services.

**441—83.109(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

**83.109(1) Appeal to county.** Rescinded IAB 2/7/01, effective 2/1/01.

**83.109(2) Reconsideration request to IME medical services unit.** Rescinded IAB 9/5/12, effective 11/1/12.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

**441—83.110(249A) County reimbursement.** Rescinded IAB 10/6/99, effective 10/1/99.

**441—83.111(249A) Conversion to the X-PERT system.** Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.112 to 83.120** Reserved.

#### DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

**441—83.121(249A) Definitions.**

“*Assessment*” means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

“*Care coordinator*” means the professional who assists members in care coordination as described in 441—paragraph 78.53(1)“b.”

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the consumer.

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

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children's mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

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

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

*“IME medical services unit”* means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

*“Integrated health home”* means the provision of services to enrolled members as described in 441—subrule 78.53(1).

*“Interdisciplinary team”* means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

*“ISIS”* means the department’s individualized services information system.

*“Local office”* means a department of human services office as described in 441—subrule 1.4(2).

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

*“Medical institution”* means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

*“Mental health professional”* means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

*“Psychiatric medical institution for children level of care”* means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

*“Serious emotional disturbance”* means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as “other conditions that may be a focus of clinical attention,” unless these conditions co-occur with another diagnosable serious emotional disturbance.

*“Service plan”* means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

*“Skill development”* means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“*Targeted case management*” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“*Waiver year*” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—83.122(249A) Eligibility.** To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

**83.122(1) Age.** The consumer must be under 18 years of age.

**83.122(2) Diagnosis.** The consumer must be diagnosed with a serious emotional disturbance.

*a. Initial certification.* For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

*b. Ongoing certification.* A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

**83.122(3) Level of care.** The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant’s level of care annually based on information submitted on Form 470-4694, Case Management Comprehensive Assessment, for children aged 3 and under or on the interRAI - Child and Youth Mental Health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - Adolescent Supplement shall also be completed in addition to the interRAI - Child and Youth Mental Health (ChYMH). Form 470-4694, the interRAI - Child and Youth Mental Health (ChYMH), and the interRAI - Adolescent Supplement are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager, integrated health home care coordinator or managed care organization.

**83.122(4) Financial eligibility.** The consumer must be eligible for Medicaid as follows:

*a.* Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

*b.* Be eligible under the special income level (300 percent) coverage group; or

*c.* Become eligible through application of the institutional deeming rules; or

*d.* Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

**83.122(5) Choice of program.** The applicant must choose HCBS children’s mental health waiver services over institutional care, as indicated by the signature of the applicant’s parent or legal guardian on the assessment.

**83.122(6) Need for service.** The consumer must have service needs that can be met under the children’s mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

*a.* The consumer must be a recipient of case management or integrated health home services or be identified to receive case management or integrated health home services immediately following program enrollment.

*b.* The total cost of children’s mental health waiver services needed to meet the member’s needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed \$2,006.34 per month.

*c.* At a minimum, each consumer must receive one billable unit of a children’s mental health waiver service per calendar quarter.

*d.* A consumer may not receive children’s mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

*e.* A consumer may be enrolled in only one HCBS waiver program at a time.  
[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

**441—83.123(249A) Application.** The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children’s mental health waiver services.

**83.123(1) Program limit.** The number of persons who may be approved for the HCBS children’s mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children’s mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer’s application shall be rejected and the consumer’s name shall be placed on a waiting list.

*a.* The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member; or

(2) A written request signed and dated by a Medicaid member’s parent or legal guardian.

*b.* When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

*c.* If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) “*a.*”

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

*d.* Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

**83.123(2) Approval of waiver eligibility.**

*a. Time limit.* Applications for the HCBS children’s mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application shall be denied.

*b. Notice of decisions.* The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

**83.123(3) Effective date of eligibility.** The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

*a.* All eligibility requirements are met; and

*b.* Eligibility and level of care determinations have been made.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

**441—83.124(249A) Financial participation.** A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

**441—83.125(249A) Redetermination.** The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

**83.125(1) Eligibility review.**

*a.* Every 12 months, the department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify continuing eligibility factors as specified in rule 441—83.122(249A).

*b.* The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed information submission tool designated in 83.122(3) and other supporting documentation as relevant.

*c.* The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

*d.* The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

**83.125(2) Continuation of eligibility.** A consumer's waiver eligibility shall continue until one of the following conditions occurs.

*a.* The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

*b.* The consumer is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the consumer has spent 120 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 120 consecutive days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

*c.* The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

**83.125(3) Payment slot.** When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.126(249A) Allowable services.** Services allowable under the children’s mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

**441—83.127(249A) Service plan.** The consumer’s case manager or integrated health home care coordinator shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

**83.127(1)** The service plan shall be developed through an interdisciplinary team process.

**83.127(2)** The service plan shall be developed annually or when there is significant change in the consumer’s situation or condition.

**83.127(3)** The service plan shall be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

**83.127(4)** The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

**83.127(5)** The service plan shall identify and justify any restriction of the consumer’s rights.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17]

**441—83.128(249A) Adverse service actions.**

**83.128(1) Denial.** An application for children’s mental health waiver services shall be denied when the department determines that:

- a. The consumer is not eligible for or in need of waiver services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6) “c” or are not met by the services provided.

**83.128(2) Termination.** A consumer’s participation in the children’s mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the children’s mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) “c.”
- c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.
- d. The physical or mental condition of the consumer requires more care than can be provided in the consumer’s own home, as determined by the consumer’s case manager or integrated health home care coordinator.
- e. Service providers are not available.

**83.128(3) Reduction.** Reduction of services shall apply as specified in 441—paragraphs 130.5(3) “a” and “b.”

[ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

**441—83.129(249A) Appeal rights.** Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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TITLE X  
SUPPORT RECOVERYCHAPTER 95  
COLLECTIONS

[Prior to 7/1/83, Social Services[770] Ch 95]

[Prior to 2/11/87, Human Services[498]]

**441—95.1(252B) Definitions.**

“*Bureau chief*” shall mean the chief of the bureau of collections of the department of human services or the bureau chief’s designee.

“*Caretaker*” shall mean a custodial parent, relative or guardian whose needs are included in an assistance grant paid according to Iowa Code chapter 239B, or who is receiving this assistance on behalf of a dependent child, or who is a recipient of nonassistance child support services.

“*Child support recovery unit*” shall mean any person, unit, or other agency which is charged with the responsibility for providing or assisting in the provision of child support enforcement services pursuant to Title IV-D of the Social Security Act.

“*Current support*” shall mean those payments received in the amount, manner and frequency as specified by an order for support and which are paid to the clerk of the district court, the public agency designated as the distributor of support payments as in interstate cases, or another designated agency. Payments to persons other than the clerk of the district court or other designated agency do not satisfy the definition of support pursuant to Iowa Code section 598.22. In addition, current support shall include assessments received as specified pursuant to rule 441—156.1(234).

“*Date of collection*” shall mean the date that a support payment is received by the department or the legal entity of any state or political subdivision actually making the collection, or the date that a support payment is withheld from the income of a responsible person by an employer or other income provider, whichever is earlier.

“*Department*” shall mean the department of human services.

“*Dependent child*” shall mean a person who meets the eligibility criteria established in Iowa Code chapter 234 or 239B, and whose support is required by Iowa Code chapter 234, 239B, 252A, 252C, 252F, 252H, 252K, 598 or 600B, and any other comparable chapter.

“*Obligee*” shall mean any person or entity entitled to child support or medical support for a child.

“*Obligor*” shall mean a parent, relative or guardian, or any other designated person who is legally liable for the support of a child or a child’s caretaker.

“*Prepayment*” shall mean payment toward an ongoing support obligation when the payment exceeds the current support obligation and amounts due for past months are fully paid.

“*Public assistance*” shall mean assistance provided according to Iowa Code chapter 239B or 249A, the cost of foster care provided by the department according to chapter 234, or assistance provided under comparable laws of other states.

“*Responsible person*” shall mean a parent, relative or guardian, or any other designated person who is or may be declared to be legally liable for the support of a child or a child’s caretaker. For the purposes of calculating a support obligation pursuant to the mandatory child support guidelines prescribed by the Iowa Supreme Court in accordance with Iowa Code section 598.21B, this shall mean the person from whom support is sought.

“*Support*” shall mean child support or medical support or both for purposes of establishing, modifying or enforcing orders, and spousal support for purposes of enforcing an order.

This rule is intended to implement Iowa Code chapters 252B, 252C and 252D.  
[ARC 1357C, IAB 3/5/14, effective 5/1/14; ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—95.2(252B) Child support recovery eligibility and services.**

**95.2(1) Public assistance cases.** The child support recovery unit shall provide paternity establishment and support establishment, modification and enforcement services, as appropriate, under federal and state laws and rules for children and families referred to the unit who have applied for or are receiving public assistance. Referrals under this subrule may be made by the family investment

program, the Medicaid program, the foster care program or agencies of other states providing child support services under Title IV-D of the Social Security Act for recipients of public assistance.

**95.2(2) *Nonpublic assistance cases.*** The same services provided by the child support recovery unit for public assistance cases shall also be made available to any person not otherwise eligible for public assistance. The services shall be made available to persons upon the completion and filing of an application with the child support recovery unit except that an application shall not be required to provide services to the following persons:

- a.* Persons not receiving public assistance for whom an agency of another state providing Title IV-D child support recovery services has requested services.
- b.* Persons for whom a foreign reciprocating country or a foreign country with which this state has an arrangement as provided in 42 U.S.C. §659 has requested services.
- c.* Persons who are eligible for continued services upon termination of assistance under the family investment program or Medicaid.

**95.2(3) *Services available.*** Except as provided by separate rule, the child support recovery unit shall provide the same services as the unit provides for public assistance recipients to persons not otherwise eligible for services as public assistance recipients. The child support recovery unit shall determine the appropriate enforcement procedure to be used. The services are limited to the establishment of paternity, the establishment and enforcement of child support obligations and medical support obligations, and the enforcement of spousal support orders if the spouse is the custodial parent of a child for whom the department is enforcing a child support or medical support order.

**95.2(4) *Application for services.***

A person who is not on public assistance requesting services under this chapter, except for those persons eligible to receive support services under paragraphs 95.2(2) “*a,*” “*b,*” and “*c,*” shall complete and return Form 470-0188, Application for Nonassistance Support Services, for each parent from whom the person is seeking support.

- a.* The application shall be returned to the child support recovery unit serving the county where the person resides. If the person does not live in the state, the application form shall be returned to the county in which the support order is entered or in which the other parent or putative father resides.
- b.* The person requesting services has the option to seek support from one or both of the child’s parents.

This rule is intended to implement Iowa Code sections 252B.3 and 252B.4.  
[ARC 4901C, IAB 2/12/20, effective 3/18/20]

**441—95.3(252B) *Crediting of current and delinquent support.*** The amounts received as support from the obligor shall be credited as the required support obligation for the month in which they are collected. Any excess shall be credited as delinquent payments and shall be applied to the immediately preceding month, and then to the next immediately preceding month until all excess has been applied. Funds received as a result of federal tax offsets shall be credited according to rule 441—98.84(252B).

The date of collection shall be determined as follows:

**95.3(1) *Payments from income withholding.*** Payments collected as the result of income withholding are considered collected in the month in which the income was withheld by the income provider. The date of collection shall be the date on which the income was withheld.

- a.* For the purpose of reporting the date the income was withheld, the department shall notify income providers of the requirement to report the date income was withheld and shall provide Form 470-3221, “Income Withholding Return Document,” to those income providers who manually remit payments. When reported on this form or through other electronic means or multiple account listings, the date of collection shall be used to determine support distributions. When the date of collection is not reported, support distributions shall initially be issued based on the date of the check. If proof of the date of collection is subsequently provided, any additional payments due the recipient shall be issued.

- b.* When the collection services center (CSC) is notified or otherwise becomes aware that a payment received from an income provider pursuant to 441—Chapter 98, Division II, includes payment amounts such as vacation pay or severance pay, these amounts are considered irrevocably withheld in

the months documented by the income provider. When the income provider does not document the months for which the sums are withheld, the amounts shall initially be distributed based on the date of the check. If documentation is subsequently provided, any additional payments due the recipient shall be issued.

**95.3(2) *Payments from state or political subdivisions.*** Payments collected from any state or political subdivision are considered collected in the same month the payments were actually received by that legal entity or the month withheld by an income provider, whichever is earlier. Any state or political subdivision transmitting payments to the department shall be responsible for reporting the date the payments were collected. When the date of collection is not reported, support distributions shall be initially issued based on the date of the state's or political subdivision's check. If proof of the date of collection is subsequently provided, any additional payments due the recipient shall be issued.

**95.3(3) *Additional payments.*** An additional payment in the month which is received within five calendar days prior to the end of the month shall be considered collected in the next month if:

- a. CSC is notified or otherwise becomes aware that the payment is for the next month, and
- b. Support for the current month is fully paid.

This rule is intended to implement Iowa Code sections 252B.15 and 252D.17.  
[ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—95.4(252B) Prepayment of support.** Prepayment which is due to the child support obligee shall be sent to the obligee upon receipt by the department, and shall be credited as payment of future months' support. Prepayment which is due the state shall be distributed as if it were received in the month when due. Support is prepaid when amounts have been collected which fully satisfy the ongoing support obligation for the current month and all past months.

**441—95.5(252B) Lump sum settlement.**

**95.5(1)** Any lump sum settlement of child support involving an assignment of child support payments shall be negotiated in conjunction with the child support recovery unit. The child support recovery unit shall be responsible for the determination of the amount due the department, including any accrued interest on the support debt computed in accordance with Iowa Code section 535.3 for court judgments. This determination of the amount due shall be made in accordance with Section 302.51, Code of Federal Regulations, Title 45 as amended to August 4, 1989. The bureau chief may waive collection of the accrued interest when negotiating a lump sum settlement of a support debt, if the waiver will facilitate the collection of the support debt.

**95.5(2)** The child support recovery unit shall be responsible for the determination of the department's entitlement to all or any of the lump sum payment in a paternity action.

This rule is intended to implement Iowa Code chapter 252C.

**441—95.6(252B) Offset against state income tax refund or rebate.** Rescinded ARC 5417C, IAB 2/10/21, effective 4/1/21.

**441—95.7(252B) Offset against federal income tax refund and federal nontax payment.** Rescinded ARC 5417C, IAB 2/10/21, effective 4/1/21.

**441—95.8(96) Child support offset of unemployment insurance benefits.** Rescinded ARC 5417C, IAB 2/10/21, effective 4/1/21.

**441—95.9** Reserved.

**441—95.10(252C) Mandatory assignment of wages.** Rescinded IAB 9/5/90, effective 11/1/90.

**441—95.11(252C) Establishment of an administrative order.** Rescinded IAB 9/1/93, effective 11/1/93. See 441—99.41(252C).

**441—95.12(252B) Procedures for providing information to consumer reporting agencies.** Rescinded ARC 5417C, IAB 2/10/21, effective 4/1/21.

**441—95.13(17A) Appeals.** Nonreceipt of support collected by the department that is to be paid to the obligee may be appealed pursuant to the procedures provided in this rule if the obligee claims that the payment was credited to the incorrect month in accordance with subrules 95.3(1), 95.3(2), and 95.3(3).

**95.13(1) Contact with department.** Obligees who believe they have not received all or part of a support payment to which they are entitled in accordance with subrules 95.3(1), 95.3(2), and 95.3(3) must first contact a customer service representative and indicate that they have not received the payment.

*a.* An obligee may contact a customer service representative in person at the department's collection services center, by telephone through the specialized customer services unit, or by writing to the Collection Services Center, 727 East 2nd Street, Des Moines, Iowa 50306.

*b.* The department will acknowledge this contact in writing, indicating the months at issue.

**95.13(2) Written decision.** Within 30 days of the contact, the department shall issue a written decision on all contested support distributions based on the date of collection.

**95.13(3) Initiation of appeal.** If the department denies some or all support payments that are claimed based on the date of collection, the obligee may initiate an administrative appeal.

*a.* To initiate an administrative appeal, the obligee shall make a written request to the child support recovery unit indicating an intent to appeal.

*b.* The time limit for initiating an administrative appeal shall be governed by 441—subrule 7.4(3). The time limit provided in 441—subrule 7.4(3) shall start with the date that a written decision as required by subrule 95.13(2) is issued.

*c.* If no written decision has been issued after 30 days, the obligee may appeal the failure to issue a written decision. The appeal may be initiated at any time after 30 days and before a written decision is issued.

**95.13(4) Limitation of appeals.** Appeals will be limited to claims based on child support received by the department during the nine-month period before the month in which the appeal is initiated.

**95.13(5) Appeal process.** Except as specifically provided in this rule, administrative appeals shall be governed by 441—Chapter 7.

**95.13(6) Appeal issue.** The issue in appeals held pursuant to these procedures shall be limited to the obligee's entitlement to a support payment that has been collected by the department.

This rule is intended to implement Iowa Code sections 17A.12 to 17A.20.  
[ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—95.14(252B) Termination of services.**

**95.14(1) Case closure criteria.**

*a.* The child support recovery unit may terminate services when the case meets at least one of the following case closure criteria and the child support recovery unit maintains supporting documentation for the case closure decision in the record:

(1) There is no ongoing support obligation, and arrearages are under \$500 or unenforceable under state law.

(2) The noncustodial parent or alleged father is deceased, and no further action, including a levy against the estate, can be taken.

(3) The noncustodial parent is living with the minor child as the primary caregiver, the custodial parent is deceased, and there is no assignment to the state of support or of arrearages that accrued under the support order.

(4) The child support recovery unit cannot establish paternity because:

1. The child is at least 18 years old and the statute of limitations bars an action to establish paternity;

2. A genetic test or a court or administrative process has excluded the alleged father and no other alleged father can be identified;

3. The child support recovery unit has determined that it would not be in the best interest of the child to establish paternity in a case that involves incest or rape or a case in which legal proceedings for adoption are pending; or

4. The identity of the biological father is unknown and cannot be identified after diligent efforts, including at least one interview by the child support recovery unit with the recipient of services.

(5) The noncustodial parent's location is unknown and the child support recovery unit has made diligent efforts to locate the noncustodial parent using multiple sources, in accordance with regulations in 45 CFR 303.3, all of which have been unsuccessful, within the applicable time frame:

1. Over a three-year period when there is sufficient information to initiate an automated locate effort.

2. Over a one-year period when there is not sufficient information to initiate an automated locate effort.

(6) The child support recovery unit has determined that, throughout the duration of the child's minority (or after the child has reached the age of majority), the noncustodial parent cannot pay support and shows no evidence of support potential because the parent has been institutionalized in a psychiatric facility, is incarcerated, or has a medically verified total and permanent disability. The child support recovery unit must also determine that the noncustodial parent has no income or assets available above the subsistence level that could be levied or attached for support.

(7) The noncustodial parent's sole income is from supplemental security income (SSI) payments.

(8) The noncustodial parent is a citizen of and lives in a foreign country, does not work for the federal government or a company with headquarters or offices in the United States, and has no reachable domestic income or assets, and there is no federal or state treaty or reciprocity with the country.

(9) In a case involving child support services to a person who is not a recipient of public assistance, the child support recovery unit has provided location-only services.

(10) The child support recovery unit has received a written or verbal request from the recipient of services to close the case, and there is no assignment to the state of support or of arrearages that accrued under the support order.

(11) In a case involving child support services to a recipient of public assistance, there has been a finding of good cause or other exception in a public assistance case as specified in 441—subrules 41.22(8) through 41.22(12) and 441—subrule 75.14(3), including a determination that support enforcement may not proceed without risk or harm to the child or caretaker relative.

(12) In a case involving child support services to a person who is not a recipient of public assistance or who is a recipient of public assistance receiving Medicaid only, the child support recovery unit has received information that the address in the unit's record is no longer current and the unit is unable to contact or otherwise locate the recipient within 60 days following receipt of this information, despite a good-faith effort to contact the recipient through at least two different methods.

(13) In a case involving child support services to a person who is not a recipient of public assistance or who is a recipient of public assistance receiving Medicaid only, the recipient of services has failed to cooperate with the child support recovery unit, which documented the circumstances of the noncooperation, and an action by the recipient of services is essential for the next step in providing services. (See rule 441—95.19(252B).)

(14) The child support recovery unit documents failure by the initiating agency, as defined under 45 CFR 301.1, to take an action that is essential for the next step in providing services.

(15) The initiating agency, as defined under 45 CFR 301.1, has notified the child support recovery unit that the initiating agency has closed its case.

(16) The initiating agency, as defined under 45 CFR 301.1, has notified the child support recovery unit that its intergovernmental services are no longer needed.

(17) Another assistance program, including IV-A, IV-E, SNAP, and Medicaid, has referred to the child support recovery unit a case for which it is inappropriate to establish, enforce, or continue to enforce a child support order and the custodial or noncustodial parent has not applied for child support services.

(18) The case meets any other basis for case closure based upon federal law.

*b.* The child support recovery unit may terminate services when no support or arrearages that accrued under the support order are assigned to the state and the recipient of services requested the child support recovery unit to close the case to allow the tribal IV-D agency to start providing services under that program.

*c.* The child support recovery unit must close a case and maintain supporting documentation for the case closure decision when the following criteria have been met:

(1) The child support recovery unit is notified that the child is eligible for health care services from the Indian Health Service (IHS); and

1. The IV-D case was opened because of a Medicaid referral based solely upon health care services, including the Purchased/Referred Care Program, provided through an Indian health program (as defined at 25 U.S.C. 1603(12)); and

2. The recipient of services requested the child support recovery unit to close the case.

(2) The child support recovery unit receives instructions for case closure from an initiating agency, as defined under 45 CFR 301.1. Within ten working days, the child support recovery unit must stop the income withholding order or notice and close the intergovernmental IV-D case.

**95.14(2) Case closure notifications.** In cases meeting one of the criteria of 95.14(1), except 95.14(1) “a”(9), (10), or (11), the child support recovery unit shall send notification of its intent to close the case to the recipient of services or the initiating agency, as defined under 45 CFR 301.1, in writing 60 calendar days before case closure. The notice shall be sent to the recipient of services or the state requesting services at the last-known address stating the reason for denying or terminating services, the effective date, and an explanation of the right to request a hearing according to 441—Chapter 7. Closure of the case following notification is subject to the following:

*a.* If, in response to the notice, the recipient of services or the initiating agency, as defined under 45 CFR 301.1, supplies information which could lead to the establishment of paternity or a support order or enforcement of an order, the case shall be kept open.

*b.* If the case is to be closed because the child support recovery unit was unable to contact the recipient of services as provided in subparagraph 95.14(1) “a”(12), the case shall be kept open if contact is reestablished with the recipient of services before the effective date of the closure.

*c.* The recipient of services may request to have the child support recovery unit reopen the case at a later date if there is a change in circumstances which could lead to the establishment of paternity or a support order or enforcement of an order by completing a new application and paying any applicable fee.

*d.* For notices under this subrule, if the recipient of services specifically authorizes consent for electronic notifications, the child support recovery unit may elect to notify the recipient of services electronically of the child support recovery unit’s intent to close the case. The child support recovery unit must maintain documentation of the recipient’s consent in the case record.

This rule is intended to implement Iowa Code sections 252B.4, 252B.5, and 252B.6.  
[ARC 3719C, IAB 3/28/18, effective 7/1/18]

#### **441—95.15(252B) Child support recovery unit attorney.**

**95.15(1) State’s representative.** An assistant attorney general, assistant county attorney, or independent contract attorney employed by or under contract with the child support recovery unit represents only the state of Iowa. The sole attorney-client relationship for the child support recovery unit attorney is between the attorney and the state of Iowa. A private attorney acting under Iowa Code section 252B.6A is not a child support recovery unit attorney, and is not a party to the action.

**95.15(2) Provision of services.** The special role of the child support recovery unit attorney is limited by the attorney-client relationship between the attorney and the state of Iowa. The provision of legal services by the child support recovery unit attorney is limited as follows:

*a.* The child support recovery unit attorney shall not represent any person or entity other than the state of Iowa in the course of the attorney’s employment by or contractual relationship with the child support recovery unit.

b. The child support recovery unit attorney shall issue written disclosure of the attorney-client relationship between the attorney and the state of Iowa to recipients of child support enforcement services and to all parties in a review and adjustment proceeding.

**95.15(3) Communication concerning case circumstances.**

a. The child support recovery unit shall provide case status information upon written request by any recipient of child support enforcement services or any party under the review and adjustment procedure, unless otherwise prohibited by state or federal statute or rules pertaining to confidentiality.

b. All communications with other parties will be directed to those parties personally, unless a licensed attorney has entered an appearance or notified the child support recovery unit in writing that the attorney is representing a party. If any party is represented by counsel, all communications shall be directed to counsel for that party.

c. When a party is receiving public assistance, the unit shall refer any suspected fraud or questionable family investment program expenditures to the appropriate governmental agencies.

This rule is intended to implement Iowa Code sections 252B.5 to 252B.7 and 598.21.

**441—95.16(252B) Handling and use of federal 1099 information.** Data from the collection and reporting system is matched with federal 1099 records for information on assets and income. Verified 1099 information may be used for: establishing support orders, modifying support orders under the review and adjustment process and enforcing payment of support debts.

**95.16(1) Security of 1099 information.** Information received from the federal source, 1099, shall be safeguarded in accordance with Internal Revenue Code Section 6103(p)(4). Information shall be kept in a secure section of the state computer system and not released until verified by a third party.

**95.16(2) Verification of 1099 information.** Prior to release of any information to the local child support recovery office, the information shall be verified by a third party as follows:

a. When information indicates there may be assets available from a financial institution, the child support recovery unit shall secure verification of these assets from the financial institution on Form 470-3170, Asset Verification Form.

b. When address information is received, the child support recovery unit shall secure verification of the address information from the post office on Form 470-0176, Address Information Request.

c. When employment information is received, the child support recovery unit shall secure verification of the employment from the employer on Form 470-0177, Employer Information Request.

This rule is intended to implement Iowa Code section 252B.9.

**441—95.17(252B) Effective date of support.** For all original orders established by the child support recovery unit, the effective date of the support obligation under the orders shall be the twentieth day following the date the order is prepared by the unit, unless otherwise specified.

**441—95.18(252B) Continued services available to canceled family investment program (FIP) or Medicaid recipients.** Support services shall automatically be provided to persons who were eligible to receive support services as recipients of FIP or Medicaid and who were canceled from FIP or Medicaid. Continued support services shall not be provided to a person who has been canceled from FIP or Medicaid when a claim of good cause, as defined at 441—subrule 41.22(8) or 441—subrule 75.14(3), as appropriate, was valid at the time assistance was canceled or when one of the reasons for termination of services, listed at rule 441—95.14(252B), applies to the case.

Support services shall be provided to eligible persons without application or application fee, but subject to applicable enforcement fees.

**95.18(1) Notice of services.** When a family is no longer eligible for public assistance, the department shall forward Form 470-1981, Notice of Continued Support Services, to the family's last-known address within five working days of the notification of ineligibility, to inform the family:

a. That, unless the family notifies the department to the contrary, services will continue.

b. Of the effect of continuing to receive support services, including the available services and the state's policies on fees, cost recovery, and distribution.

**95.18(2) Termination of services.** A person may request the department to terminate support services at any time by the completion and return of the appropriate portion of Form 470-1981, Notice of Continued Support Services, or in any other form of written communication, to the child support recovery unit.

Continued support services may be terminated at any time for any of the reasons listed in rule 441—95.14(252B).

**95.18(3) Reapplication for services.** A person whose services were denied or terminated may reapply for services under this chapter by completing the application process described in subrule 95.2(4).

This rule is intended to implement Iowa Code section 252B.4.  
[ARC 4901C, IAB 2/12/20, effective 3/18/20]

**441—95.19(252B) Cooperation of public assistance recipients in establishing and obtaining support.** If a person who is a recipient of FIP or Medicaid is required to cooperate with the child support recovery unit in establishing paternity; in establishing, modifying, or enforcing child or medical support; or in enforcing spousal support, the following shall apply:

**95.19(1) Cooperation defined.** The person shall cooperate in good faith in obtaining support for persons whose needs are included in the assistance grant or Medicaid household, except when good cause or other exception as defined in 441—subrule 41.22(8) or 75.14(8) for refusal to cooperate, is established.

*a.* The person shall cooperate in the following areas:

- (1) Identifying and locating the parent of the child for whom assistance or Medicaid is claimed.
- (2) Establishing the paternity of a child born out of wedlock for whom assistance or Medicaid is claimed.
- (3) Obtaining support payments for the person and the child for whom assistance is claimed, and obtaining medical support for the person and child for whom Medicaid is claimed.

*b.* Cooperation is defined as including the following actions by the person if the action is requested by the child support recovery unit:

- (1) Providing the name of the noncustodial parent and additional necessary information.
- (2) Appearing at the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the person that is relevant to achieving the objectives of the child support recovery program.
- (3) Appearing at judicial or other hearings, proceedings or interviews.
- (4) Providing information or attesting to the lack of information, under penalty of perjury.
- (5) If the paternity of the child has not been legally established, submitting to blood or genetic tests pursuant to a judicial or administrative order. The person may be requested to sign a voluntary affidavit of paternity after being given notice of the rights and consequences of signing such an affidavit as required by the statute in Iowa Code section 252A.3A. However, the person shall not be required to sign an affidavit or otherwise relinquish the right to blood or genetic tests.

*c.* The person shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the noncustodial parent and taking action as may be necessary to secure or enforce a support obligation or establish paternity or to secure medical support. This includes completing and signing Form 470-3877, Child Support Information, if requested, as well as documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

**95.19(2) Failure to cooperate.** The local child support recovery unit shall make the determination of whether or not a person has cooperated with the unit. The child support recovery unit shall promptly send notice of a determination of noncooperation to the person on Form 470-3400, Notice of Noncooperation, and notify the FIP and Medicaid programs, as appropriate, of the noncooperation determination and the reason for the determination. The FIP and Medicaid programs shall take appropriate sanctioning actions as provided in statute and rules.

**95.19(3) Good cause or other exception.**

*a.* A person who is a recipient of FIP assistance may claim a good cause or other exception for not cooperating, taking into consideration the best interests of the child as provided in 441—subrules 41.22(8) through 41.22(12).

*b.* A person who is a recipient of Medicaid may claim a good cause or other exception for not cooperating, taking into consideration the best interests of the child as provided in 441—subrule 75.14(3).

This rule is intended to implement Iowa Code section 252B.3.

**441—95.20(252B) Cooperation of public assistance applicants in establishing and obtaining support.** If a person who is an applicant of FIP or Medicaid is required to cooperate in establishing paternity; in establishing, modifying, or enforcing child or medical support; or in enforcing spousal support, the requirements in 441—subrule 41.22(6) and rule 441—75.14(249A) shall apply. The appropriate staff in the FIP and Medicaid programs are designees of the child support recovery unit to determine noncooperation and issue notices of that determination until the referral to the unit is completed.

This rule is intended to implement Iowa Code section 252B.3.

**441—95.21(252B) Cooperation in establishing and obtaining support in nonpublic assistance cases.**

**95.21(1) Requirements.** The individual receiving nonpublic assistance support services shall cooperate with the child support recovery unit by meeting all the requirements of rule 441—95.19(252B), except that the individual may not claim good cause or other exception for not cooperating.

**95.21(2) Failure to cooperate.** The child support recovery unit shall make the determination of whether or not the nonpublic assistance applicant or recipient of services has cooperated. Noncooperation shall result in termination of support services. An applicant or recipient may also request termination of services under 95.14(1)“b”(1).

This rule is intended to implement Iowa Code section 252B.4.

**441—95.22(252B) Charging pass-through fees.** Pass-through fees are fees or costs incurred by the department for service of process, genetic testing and court costs if the entity providing the service charges a fee for the services. The child support recovery unit may charge pass-through fees to persons who receive continued services according to rule 441—95.18(252B) and to other persons receiving nonassistance services, except no fees may be charged an obligee residing in a foreign country or the foreign country if the unit is providing services under paragraph 95.2(2)“b.”

This rule is intended to implement Iowa Code section 252B.4.

**441—95.23(252B) Reimbursing assistance with collections of assigned support.** For an obligee and child who currently receive assistance under the family investment program, the full amount of any assigned support collection that the department receives shall be distributed according to rule 441—95.3(252B) and retained by the department to reimburse the family investment program assistance.

This rule is intended to implement Iowa Code section 252B.15.

**441—95.24(252B) Child support account.** The child support recovery unit shall maintain a child support account for each client. The account, representing money due the department, shall cover all periods of time public assistance has been paid, commencing with the date of the assignment. The child support recovery unit will not maintain an interest-bearing account.

This rule is intended to implement Iowa Code chapter 252C.

**441—95.25(252B) Emancipation verification.** The child support recovery unit (CSRU) may verify whether a child will emancipate according to the provisions established in the court order prior to the child’s eighteenth birthday.

**95.25(1) Verification process.** CSRU shall send Form 470-2562, Emancipation Verification, to the obligor and obligee on a case if CSRU has an address.

**95.25(2) Return information.** The obligor and obligee shall be asked to complete and return the form to the unit. CSRU shall use the information provided by the obligor or obligee to determine if the status of the child indicates that any previously ordered adjustments related to the obligation and a child's emancipation are necessary on the case.

**95.25(3) Failure to return information.** If the obligor and obligee fail to return the questionnaire, CSRU shall apply the earliest emancipation date established in the support order to the case and implement changes in support amounts required in the support order.

**95.25(4) Conflicting information returned.** If conflicting information is returned or made known to CSRU, CSRU shall have the right to verify the child's status through sources other than the obligor and obligee.

This rule is intended to implement Iowa Code sections 252B.3 and 252B.4.

#### **441—95.26(17A) Right of appeal.**

**95.26(1)** Under this chapter, an administrative appeal pursuant to 441—Chapter 7 shall be limited to the following issues:

*a.* A person 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 a dispute based on the date of collection has not been acted on in a timely manner.

*b.* A termination in services has occurred as provided in rule 441—95.14(252B).

**95.26(2)** A hearing shall not be granted under 441—Chapter 7 when the appellant has a complaint about child support recovery unit collections actions other than those described in this rule. This includes the collection of an annual fee for child support services as specified in Iowa Code chapter 252B.

This rule is intended to implement Iowa Code sections 17A.12 to 17A.20.

[ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—95.27(17A) Appeal record.** The record in an administrative appeal under this rule shall include, in addition to those materials specified in Iowa Code section 17A.12(6), the notice of appeal, all evidence received or considered and all other submissions, including the verbatim record of the hearing.

This rule is intended to implement Iowa Code section 17A.12.

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<sup>1</sup> Two ARCs

<sup>2</sup> Effective date of 95.1, definition of “Date of collection,” and 95.3 delayed 70 days by the Administrative Rules Review Committee at its meeting held September 15, 1999; delayed until the end of the 2000 Session of the General Assembly at its meeting held October 11, 1999.



CHAPTER 96  
INFORMATION AND RECORDS

PREAMBLE

Title IV-D of the Social Security Act provides that state child support agencies providing services under the Act shall have access to information and records from third parties to assist in providing services. Information and records shall be provided as specified in these rules, other rules, Iowa statutes, and federal statute and regulations. These rules implement a procedure for the child support agency to request or administratively subpoena information from employers and other sources, and provide an appeal procedure before imposition of the statutory fine for failure to comply.

**441—96.1(252B) Access to information and records from other sources.** In addition to statutes and other rules, the following entities shall provide information and records based on the following methods of requesting the information and within the following time frame:

**96.1(1) *Oral or written request.*** All persons and entities, including all for-profit, nonprofit, and governmental employers, shall, within 15 days of receipt of a request, provide the child support recovery unit or a child support agency of another state information on the employment, compensation, and benefits of any individual employed by the person or entity as an employee or contractor if the unit or agency is providing services in relation to that individual. The request may be made orally, by letter, by form or by other written request listed in subrule 96.1(3); however, the fine and procedures described in rules 441—96.2(252B) to 441—96.6(252B) only apply if the request was by a written request listed in subrule 96.1(3).

**96.1(2) *Subpoena.*** All persons and entities shall comply with a Child Support Recovery Unit Subpoena, Form 470-3413, issued by the child support recovery unit, or an Administrative Subpoena, OMB Control # 0970-0152, or its successor, issued by the unit or a child support agency of another state, as provided in Iowa Code section 252B.9. The child support recovery unit or a child support agency of another state may issue a subpoena regarding more than one individual. The person or entity shall provide the information and records as directed in Form 470-3413 or the Administrative Subpoena.

**96.1(3) *Time to reply to a written request.*** A person or entity who is sent any of the following shall provide the information and records requested in the manner requested to the child support recovery unit or child support agency of another state, as appropriate, within 15 days of the date of the request.

*a.* Form 470-3232, Employer Verification Request, Form 470-0177, Employment and Health Insurance Questionnaire, or other forms as specified in appropriate rules from the child support recovery unit which request information described at subrule 96.1(1).

*b.* Form 470-3413, Child Support Recovery Unit Subpoena, or an Administrative Subpoena, OMB Control # 0970-0152, or its successor, as provided at subrule 96.1(2), from the child support recovery unit.

*c.* A written request or form as provided at subrule 96.1(1) from a child support agency of another state.

*d.* An Administrative Subpoena, OMB Control # 0970-0152, or its successor, as provided at subrule 96.1(2), from a child support agency of another state.

**441—96.2(252B) Refusal to comply with written request or subpoena.**

**96.2(1)** A parent or putative father in a support or paternity proceeding in which the child support recovery unit or a child support agency of another state is providing services who fails to comply with a request or subpoena as provided in subrule 96.1(3) shall be subject to license sanctioning as provided in 441—Chapter 98, Division VIII.

**96.2(2)** An entity or a person who is not a parent or putative father as described in subrule 96.2(1) may refuse to comply under the circumstances provided in rule 441—96.3(252B).

**441—96.3(252B) Procedure for refusal.**

**96.3(1) *No information.*** A person or entity who does not have any information or records requested or subpoenaed shall respond as follows:

*a.* If the request or subpoena is a form from the child support recovery unit under paragraph 96.1(3) “*a*” or “*b*,” the person or entity shall sign and return to the unit the appropriate portion of the form indicating the lack of information or records.

*b.* If the request or subpoena is one listed in paragraphs 96.1(3) “*c*” or “*d*,” the person or entity shall send the child support agency of the other state a signed and dated written statement indicating the lack of information or records.

**96.3(2) *Good cause.*** The person or entity may claim good cause for refusing to comply as required in Iowa Code section 252B.9.

*a.* To claim good cause, the person or entity shall file a request for a conference by mailing or submitting a written request to the child support recovery unit which issued the request or subpoena within 15 days of the issuance of the request or subpoena.

*b.* If a child support agency of another state issued the request or subpoena, the person or entity may request a conference with the child support recovery unit or with the child support agency of the other state. The person or entity shall request a conference with the child support recovery unit by mailing or submitting a written request and a copy of the subpoena or document received from the child support agency of the other state to the Iowa Department of Human Services, Bureau of Collections, Central Registry, P.O. Box 9218, Des Moines, Iowa 50306-9218. The person or entity shall request a conference with the child support agency of the other state by following the requirements of that state’s laws and regulations.

#### **441—96.4(252B) Conference conducted.**

**96.4(1) *Request or subpoena issued by CSRU.*** If the child support recovery unit issued the request or subpoena, the unit shall notify the person or entity and conduct a conference within ten days of receipt of the request for a conference. At the request of either the unit or the person or entity, the conference may be rescheduled one time. The conference may be conducted in person or by telephone.

**96.4(2) *Request or subpoena issued by other state.*** If a conference with the child support recovery unit is requested based upon a request or subpoena issued by a child support agency of another state, the bureau chief, as defined at rule 441—95.1(252B), shall request that agency send an interstate referral and appropriate information to the unit or central registry.

*a.* The child support recovery unit shall notify the person or entity and conduct a conference within ten days of opening a case based upon an interstate referral and appropriate information. If the child support recovery unit does not receive an interstate referral and appropriate information within 60 days of the bureau chief’s request, the request or subpoena received under subrule 96.1(3) shall be void, and the child support recovery unit shall notify the person or entity it is void.

*b.* The voiding of a request or subpoena under this subrule shall not prevent the issuance of subsequent requests or subpoenas.

**96.4(3) *Submission of information.*** On or before the conference date, the person or entity shall submit information to the child support recovery unit which demonstrates a mistake in the identity of the person or entity, or a mistake in the identity of the individual who is the subject of the request or subpoena, or which demonstrates a specific prohibition under federal law to release of the information or records. The child support recovery unit may extend the time to conduct the conference an additional ten days to allow time for the person or entity to provide the information.

**96.4(4) *Notice of findings.*** Following the conference, the unit shall issue a notice as provided in Iowa Code section 252B.9.

#### **441—96.5(252B) Fine assessed.**

**96.5(1) *Conditions resulting in fine.*** The child support recovery unit shall assess a fine of \$100 per refusal and notify the person or entity of the fine if any one of the following applies:

a. Ten days have passed since the unit issued a notice under subrule 96.4(4) stating the unit determined there is no good cause to refuse to comply with the request or subpoena, and the information or records have not been received.

b. Fifteen days have passed since the child support recovery unit issued the request or subpoena and the information or records have not been received, nor has the person or entity filed a request for a conference.

c. Fifteen days have passed since a child support agency of another state has issued the request or subpoena, and that agency sends an interstate referral to the child support recovery unit requesting enforcement of the request or subpoena because the information or records were not received.

**96.5(2) *Definition of refusal.*** One refusal is a refusal to supply information or records based on one written request, or one subpoena regarding one or more individuals.

**96.5(3) *Notification of fine.*** If the child support recovery unit assesses a fine, the unit shall notify the person or entity by regular mail with proof of service completed according to Rule of Civil Procedure 1.442. The person or entity shall have 30 days from the date of the notice to pay the fine.

**441—96.6(252B) Objection to fine or failure to pay.**

**96.6(1) *Objection filed.*** The person or entity may object to the imposition of the fine by filing an application for judicial review in district court within 30 days of issuance of the notice of the fine, and sending a copy of the application to the child support recovery unit.

**96.6(2) *Petition to compel.*** If the person or entity fails to pay the fine imposed, and does not file an application for judicial review within the time provided in this rule, the child support recovery unit may file a petition to compel the person or entity to comply with the request, subpoena or fine in district court in the county in which the underlying support order or pending matter is filed. If there is no support order or pending matter filed in district court in Iowa, then the unit may file the petition in the county in which the person resides, or the person or entity has its principal place of business.

**96.6(3) *Certification to court.*** If the person, entity, or the child support recovery unit files an action in district court, the unit shall certify a copy of the following, as appropriate, to the court prior to a hearing:

- a. Proof of service of the request or subpoena.
- b. Proof of service of the notice of assessment of a fine.
- c. Written decision following a conference.

**96.6(4) *Failure to comply with court order.*** Failure of the person or entity to comply with an order of the district court shall be subject to enforcement through contempt of court.

**441—96.7(17A) Right of appeal.** Department actions under this chapter are not subject to administrative appeal under 441—Chapter 7.

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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.

*“Website”* means the website 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 website.** 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 website 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 website 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 website 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 website 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 website 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. 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.

[ARC 4576C, IAB 7/31/19, effective 9/4/19]

**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.

**441—97.8(17A) Right of appeal.** Department actions under this chapter are not subject to administrative appeal under 441—Chapter 7.

[ARC 5417C, IAB 2/10/21, effective 4/1/21]

These rules are intended to implement Iowa Code chapter 17A and sections 252B.13A through 252B.17 and 252D.17.

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CHAPTER 98  
SUPPORT ENFORCEMENT SERVICES

PREAMBLE

The child support recovery unit is charged with the responsibility to provide the enforcement services delineated in this chapter.

[ARC 5417C, IAB 2/10/21, effective 4/1/21]

DIVISION I  
MEDICAL SUPPORT ENFORCEMENT

**441—98.1(252E) Definitions.**

*“Medical support”* means either the provision of health care coverage or the payment of cash medical support. Medical support is not alimony.

*“Obligee”* means a parent or other natural person legally entitled to receive a support payment on behalf of a child.

*“Obligor”* means a parent or other natural person legally responsible for the support of a dependent.  
[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.2(252E) Provision of services.** The child support recovery unit shall provide medical support services to public assistance and nonpublic assistance recipients of child support services. Unless good cause has been established, recipients of public assistance are required to cooperate with the child support recovery unit as a condition of eligibility as prescribed in rule 441—75.14(249A).  
[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.3(252E) Establishing medical support.** Rescinded ARC 4112C, IAB 11/7/18, effective 2/15/19.

**441—98.4(252E) Accessibility of the health benefit plan.** Rescinded ARC 4112C, IAB 11/7/18, effective 2/15/19.

**441—98.5(252E) Health benefit plan information.** The unit shall gather information concerning a health benefit plan.

**98.5(1) Information from an employer.** The unit shall gather information concerning a health benefit plan an employer may offer an obligor as follows:

*a.* The unit may send Form 470-0177M, Employment and Health Insurance Questionnaire, whenever a potential employer is identified.

*b.* The unit shall secure information about health care coverage from a known employer on Form 470-2743, Employer Medical Support Information, when Form 470-3818, National Medical Support Notice, or an order has been forwarded to the employer pursuant to Iowa Code section 252E.4.

**98.5(2) Information from an obligor.** The unit may secure medical support information from an obligor on Form 470-0413, Obligor Insurance Questionnaire.

**98.5(3) Disposition of information.** The unit shall provide the information:

*a.* To the Medicaid agency and to the obligee, when requested, when the dependent is a recipient of Medicaid.

*b.* To the obligee, when requested, when the dependent is not a recipient of Medicaid.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.6(252E) Insurer authorization.** When the obligor does not provide to the insurer the signed documents necessary to enroll and process claims for the dependent for whom support is ordered, the insurer is authorized to accept the signature of the obligee or the department’s designee on necessary forms. For purposes of Division I of this chapter, the third-party liability unit is the department’s designee when support is assigned.

**441—98.7(252E) Enforcement.**

**98.7(1) *Medical support enforcement.*** For the purposes of enforcement, medical support may be reduced to a dollar amount and collected through the same remedies available for the collection and enforcement of child support.

**98.7(2) *Health care coverage.***

*a.* If an obligor was ordered to provide health care coverage under an order but did not comply with the order, the child support recovery unit may implement the order by forwarding to the employer a copy of the order, an ex parte order as provided in Iowa Code section 252E.4, or Form 470-3818, National Medical Support Notice.

*b.* If the child support recovery unit implements an order under this subrule, the unit shall send a notice to the obligor at the last-known address of the obligor by regular mail. The notice shall contain the following information:

- (1) A statement of the obligor's right to an informal conference.
- (2) The process to request an informal conference.
- (3) The obligor's right to file a motion to quash with the district court.

**98.7(3) *Termination of employment.*** When the child support recovery unit receives information indicating the obligor's employment has terminated, the unit shall secure the status of the health benefit plan by sending Form 470-3218, Employer Insurance Notification, to the employer.

If no response is received within 30 days of sending Form 470-3218, the unit shall send a second request on Form 470-3219, Employer Insurance Second Notification, to the employer.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.8(252E) Contesting the order.** The obligor may contest the enforcement of medical support by means of an informal conference with the child support recovery unit, or by filing a motion to quash.

**98.8(1) *Motion to quash.*** Procedures for filing a motion to quash the order are specified under Iowa Code sections 252D.31 and 252E.6A.

**98.8(2) *Informal conference.***

*a.* The obligor shall be entitled to only one informal conference for each new employer to which the unit has forwarded Form 470-3818, National Medical Support Notice, or order under Iowa Code section 252E.4 to enforce medical support.

*b.* Procedures for the informal conference are as follows:

(1) The child support recovery unit shall inform the obligor in writing of the right to request an informal conference.

(2) The obligor may request an informal conference with the child support recovery unit if the obligor believes the enforcement was entered in error.

(3) The obligor shall request an informal conference in writing, within 15 calendar days from the date of the notice of the right to an informal conference, or at any time if a mistake of fact regarding the identity of the obligor is believed to have been made.

(4) The child support recovery unit shall schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor's representative.

(5) The child support recovery unit may conduct the conference in person or by telephone.

(6) If the obligor fails to attend the conference, only one alternative time shall be scheduled by the child support recovery unit.

(7) The child support recovery unit shall issue a written decision to the obligor within ten calendar days of the conference.

*c.* The issues to be reviewed at the conference shall be as follows:

- (1) Whether the identity of the obligor is in error.
- (2) Whether the obligor is already providing health care coverage for the dependent.
- (3) Whether the availability of dependent health care coverage is in error.
- (4) Whether the obligor was ordered to provide health care coverage under the support order.

*d.* The results in an informal conference shall in no way affect the right of the obligor to file a motion to quash the order under Iowa Code section 252E.6A.  
[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.9 to 98.20** Reserved.

DIVISION II  
INCOME WITHHOLDING  
PART A  
DELINQUENT SUPPORT PAYMENTS

**441—98.21(252D) When applicable.** When there is a delinquency in an amount equal to the support payable for one month as specified by an order for support or reimbursement order and the child support recovery unit is providing services under 441—Chapter 95, the unit shall enter an order to withhold the obligor's income not exempt by state or federal law to require the income withheld to be paid to the collection services center to pay the support obligation. An income withholding order shall also be entered to collect the unpaid balance of a judgment for the reimbursement of a support debt when a repayment schedule is not specified in the order establishing the judgment.

**441—98.22 and 98.23** Reserved.

**441—98.24(252D) Amount of withholding.** The child support recovery unit shall determine the amount to be withheld by the employer or other income providers as follows:

**98.24(1) Current support obligation exists.** When a current support obligation exists, the amount withheld shall be an amount equal to the current support obligation, and an additional amount equal to 20 percent of the current support obligation to be applied toward the liquidation of any delinquency. However, the amount withheld to be applied toward the liquidation of any delinquency shall be 50 percent of the current support obligation for any support order entered or modified prior to July 1, 1998, and for which an income withholding order has been filed by the Iowa child support recovery unit prior to July 1, 1998.

**98.24(2) Current obligation ended.** When the current support obligation has ended or has been suspended, the income withholding order shall remain in effect until any delinquency has been satisfied. The amount withheld shall be equal to the amount of the most recent prior current support obligation which is greater than zero. However, in the following circumstances, the amount withheld shall be 20 percent of the amount owed for current support at the time the obligation ended or was suspended:

- a.* There has been a change of legal custody from the obligee to the obligor.
- b.* The obligee and obligor have reconciled and have obtained a modification ending the current support obligation.
- c.* The current obligation is suspended through the suspension process.
- d.* In a foster care case, the order for parental liability ended when the child left placement, or an order ending the liability has been entered and the child in foster care has returned to the home of a parent ordered to pay parental liability. In this situation, the amount withheld shall be reduced to 20 percent of the current support amount when the obligation ended, but only for the parent with whom the child resides.

**98.24(3) No support ordered.** When there is no current child support ordered and the obligation is solely the result of a judgment which does not specify a repayment schedule, the withholding amount shall be set at the amount for one person from the FIP schedule of basic needs.

**98.24(4) Lump-sum income source.** Notwithstanding subrules 98.24(1), 98.24(2), and 98.24(3), when the obligor is paid by a lump-sum income source, the withholding amount may include all current and delinquent support due through the current month. Lump-sum income includes income received in a sole payment or in payments that occur at two-month or greater intervals.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.25(252D) Amendment of amount of withholding due to hardship.**

**98.25(1) Request for amendment.** If subrule 98.24(2) or 98.24(3) applies, the obligor may request at any time an amendment of the amount withheld as payment toward the delinquency or reimbursement on the grounds of hardship. The obligor must submit the request in writing to the child support recovery unit.

**98.25(2) Hardship criterion.** Hardship exists if the obligor's income is equal to or less than 200 percent of the poverty level for one person according to the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

a. If hardship is claimed by the obligor, the child support recovery unit may verify income from:

- (1) The employer or other income provider of the obligor.
- (2) The obligor.
- (3) The state employment security agency.
- (4) Other records available in accordance with Iowa Code section 252B.9.

b. If the hardship criterion is met, the amount withheld as payment toward the delinquency may be amended as follows:

(1) The obligor's gross yearly income shall be divided by 200 percent of the established yearly gross poverty level income for one person. That amount shall be multiplied by .5. The resulting figure shall be multiplied by the most recent prior current support obligation or the amount determined pursuant to subrule 98.24(3), as applicable, to determine the amended amount. Notwithstanding this calculation, the amended amount shall not be less than \$15 per month.

(2) If criteria for withholding 20 percent toward liquidation of any delinquency are also met, the lesser of 20 percent or the amended amount determined in subparagraph 98.25(2) "b"(1) is to be withheld.

**98.25(3) Hardship period.** If the hardship criterion in subrule 98.25(2) is met, the child support recovery unit will grant the amended amount of withholding for a period of two years, subject to the provisions of subrule 98.25(6). However, if the obligor is receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits, the obligor is deemed to continue to meet the hardship criterion for the duration of those benefits.

**98.25(4) Denying requests.** A hardship request may be denied if:

- a. The criterion in subrule 98.25(2) is not met.
- b. The obligor has been granted an amended amount of withholding based on this rule within the last two years and that hardship period will not expire in less than 30 days.

c. The obligor's previous hardship period expired within the last six months and, within 30 days prior to the expiration date of the previous hardship period, the obligor did not submit the following to the child support recovery unit:

- (1) A written request for hardship; or
- (2) Verification of the obligor's income, and the child support recovery unit was not able to verify the obligor's income as described in paragraph 98.25(2) "a."

**98.25(5) Notice requirements.** The child support recovery unit will provide written notification to the obligor of the result of the hardship request.

a. When a hardship request is granted, the written notification will include the amended amount of withholding and the date the hardship period will expire.

b. When a hardship request is denied, the written notification will include the reason for denial.

**98.25(6) Termination of hardship prior to expiration date.** The hardship period will automatically end, regardless of expiration date, if any of the following occurs:

- a. A current support obligation is added to the support order.
- b. The current support obligation was previously suspended and is reinstated.
- c. The delinquency has been paid in full.
- d. The obligor was receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits at the time the hardship request was granted, and the child support recovery unit has verified that the obligor is no longer receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits.

**441—98.26(252D) Additional information about hardship.** The child support recovery unit shall make reasonable efforts within 13 months after January 1, 2019, to identify and incrementally notify obligors who may be impacted by the changes to hardship procedures in rule 441—98.25(252D).  
[ARC 4112C, IAB 11/7/18, effective 2/15/19]

These rules are intended to implement Iowa Code chapter 252D.

**441—98.27 to 98.30** Reserved.

PART B  
IMMEDIATE INCOME WITHHOLDING

**441—98.31(252D) Effective date.** In cases for which the child support recovery unit is providing enforcement services, the income of the obligor is subject to immediate withholding pursuant to Iowa Code section 252D.8 without regard to the existence of a delinquency in the payment of support.

**441—98.32(252D) Withholding automatic.** Immediate withholding of income is automatic without additional notice to the obligor unless:

**98.32(1) Good cause exists.** Good cause is found to exist by the court or the child support recovery unit. For purposes of this rule, “good cause” is defined as the posting of a secured bond by the obligor sufficient to pay all current and future child support obligations, including any delinquency which may accrue.

**98.32(2) Written agreement exists.** A written agreement is reached between both parties which provides for an alternative arrangement for payment of child support subject to the following conditions:

*a.* Unless approved by the child support recovery unit, written agreements between the obligee and obligor to waive immediate income withholding become void when child support is assigned to this state or to another state pursuant to a statute of that jurisdiction.

*b.* All payments pursuant to any written agreement shall be paid as directed in Iowa Code sections 252B.14 and 598.22.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.33** Reserved.

**441—98.34(252D) Approval of request for immediate income withholding.** When the obligee or other party to the proceeding requests immediate withholding, the child support recovery unit shall determine whether the request shall be approved.

**98.34(1) Basis for approval.** Approval of a request for immediate income withholding by the child support recovery unit may be based on:

*a.* Past payment record of the obligor which demonstrates an inconsistent compliance with the support order.

*b.* Whether the state of Iowa is providing public assistance.

**98.34(2) Request denied.** The child support recovery unit may not approve a request for immediate income withholding on cases where no public assistance has been expended and there is a prior written agreement between the obligee and obligor which has been approved by court order.

**441—98.35(252D) Modification or termination of withholding.** Rescinded ARC 4112C, IAB 11/7/18, effective 2/15/19.

**441—98.36(252D) Immediate income withholding amounts.** The amount withheld shall be the amount of the current support obligation as specified in the support order. If a judgment for accrued support is established in the support order, the amount withheld shall be the amount due for current support and the periodic payment amount due for the accrued support as specified in the order. If no periodic payment for the accrued support is established in the support order, the amount withheld shall be the amount due for current support plus 10 percent of the amount of the current obligation to be applied to the accrued support.

**441—98.37(252D) Immediate income withholding amounts when current support has ended.** When the child support obligation has ended, the amounts to be withheld shall be in accordance with subrule 98.24(2).

These rules are intended to implement Iowa Code chapter 252D.

**441—98.38** Reserved.

PART C  
INCOME WITHHOLDING—GENERAL PROVISIONS

**441—98.39(252D,252E) Provisions for medical support.** An income withholding order or notice of income withholding may also include provisions for enforcement of medical support when medical support is included in the support order. The income withholding order or notice of income withholding may require implementation of dependent health care coverage pursuant to Iowa Code chapter 252E or the withholding of a dollar amount for medical support. Amounts withheld for medical support shall be determined in the same manner as amounts withheld for child support.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.40(252D,252E) Maximum amounts to be withheld.** An income withholding order or a notice issued by the child support recovery unit shall require that the employer or other income provider withhold no more than the maximum amounts allowed under the Federal Consumer Credit Protection Act, 15 U.S.C. Section 1673(b).

**98.40(1)** The amount of income subject to withholding shall be limited to 50 percent of the nonexempt disposable income of the obligor unless there is more than one support order for which the obligor is obligated and the criteria of 15 U.S.C. Section 1673(b) are met, or the obligor agrees to a greater amount within these limits.

**98.40(2)** Disposable income means that part of the earnings of any individual remaining after the deduction from those earnings of any amounts required by law to be withheld.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.41(252D) Multiple obligations.** In the event that an obligor has more than one support obligation that is being enforced by the child support recovery unit, the unit may enter an income withholding order to enforce each obligation. The amount specified to be withheld on the delinquency under the income withholding order or notice shall be determined in accordance with rule 441—98.24(252D).

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.42(252D) Notice to employer and obligor.** The child support recovery unit shall send the obligor and the employer or other income provider a notice of income withholding as follows:

**98.42(1) Notice to employer.** The unit may send notice to the employer or other income provider by regular mail or by electronic means in accordance with Iowa Code chapter 252D. If the unit is sending notice by regular mail, it shall send Form 470-3272, Income Withholding for Support, or a notice in the standard format prescribed by 42 U.S.C. §666(b)(6)(A). If the unit is sending the notice by electronic means, it may include notice of more than one obligor's order and need only state once provisions which are applicable to all obligors, such as the information in paragraphs 98.42(1) "d," "f," "g," and "i." The statement of provisions applicable to all obligors may be sent by regular mail or electronic means. The notice of income withholding shall contain information such as the following:

- a. The obligor's name and social security number.
- b. The amount of current support to withhold.
- c. The amount of support to withhold for payment of delinquent support, if any.
- d. The amount an income provider may deduct for costs of processing each support payment.
- e. The child support case number.

- f.* The location to which payments are sent.
- g.* The maximum amount that can be withheld for payment of support as specified in rule 441—98.40(252D,252E).
- h.* The method to calculate net income.
- i.* Responsibilities of the income provider as specified in Iowa Code section 252D.17.
- j.* Responsibility, if any, of the income provider to enroll the obligor's dependent for coverage under a health benefit plan.

**98.42(2) *Notice to obligor.*** Form 470-2624, Initiation of Income Withholding/Medical Support Enforcement, shall be sent to the last-known address of the obligor by regular mail. The notice shall contain the following information:

- a.* A statement of the obligor's right to an informal conference.
- b.* The process to request an informal conference.
- c.* The obligor's right to claim hardship criteria and the process for a claim.
- d.* The obligor's right to file a motion to quash the income withholding order or notice with the district court.
- e.* The information provided to the employer or other income provider, or a copy of the notice sent to the employer or other income provider.
- f.* The amount of any delinquency.

**98.42(3) *Standard format.*** As provided in Iowa Code section 252D.17, an order or notice of an order for income withholding shall be in a standard format prescribed by the child support recovery unit. Form 470-3272, Income Withholding for Support, is the standard format prescribed by the child support recovery unit, and the unit shall make a copy of the form available to the state court administrator and the Iowa state bar association.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.43(252D) *Contesting the withholding.*** The obligor may contest the income withholding by means of an informal conference with the child support recovery unit or by filing a motion to quash.

**98.43(1) *Motion to quash.*** Procedures for filing a motion to quash the order or the notice of income withholding are specified in Iowa Code chapter 252D.

**98.43(2) *Informal conference.***

*a.* The obligor shall be entitled to only one informal conference for each new or modified income withholding order or notice issued by the child support recovery unit that specifies a new or modified total amount to withhold.

*b.* Procedures for the informal conference are as follows:

(1) The child support recovery unit shall inform the obligor in writing of the right to request an informal conference.

(2) The obligor may request an informal conference with the child support recovery unit if the obligor believes the withholding is in error.

(3) The obligor shall request an informal conference in writing.

(4) The child support recovery unit shall schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor's representative.

(5) The child support recovery unit may conduct the conference in person or by telephone.

(6) If the obligor fails to attend the conference, only one alternative time shall be scheduled by the child support recovery unit.

(7) The child support recovery unit shall issue a written decision to the obligor within ten calendar days of the conference.

(8) If the child support recovery unit has not complied with rule 441—98.24(252D), it shall then adjust the income withholding amount.

*c.* The issues to be reviewed at the conference shall be as follows:

(1) For all income withholding orders or notices, whether:

1. The identity of the obligor is in error.

2. The amount of the current support obligation is in error.

- (2) For orders or notices resulting from the existence of a delinquency, whether:
  1. The amount of delinquent support is in error.
  2. For income withholding orders or notices issued after November 1, 1990, whether the guidelines described at rule 441—98.24(252D) were followed.
- (3) For immediate income withholding orders or notices, whether the criteria of rules 441—98.32(252D) and 441—98.34(252D) were appropriately applied.
  - d. The results of an informal conference shall in no way affect the right of the obligor to file a motion to quash the income withholding order or notice with the court.

**98.43(3) *Income withholding issued from another state.*** The child support recovery unit shall follow procedures for a motion to quash or a request for hardship or conduct an informal conference based on an income withholding order or notice issued in another state only if the unit is providing services under 441—Chapter 95.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.44(252D) Termination of order.** The child support recovery unit may, by ex parte order, terminate an income withholding order under the following conditions:

**98.44(1) *Order entered in error.*** The child support recovery unit shall terminate an income withholding order upon determination that the order was entered in error as follows:

- a. The person named as the obligor in the income withholding order is not the person required to provide support under the support order being enforced.
- b. For orders resulting from the existence of a delinquency, the required minimum delinquency did not exist at the time the income withholding order was entered.

**98.44(2) *No support due.*** In cases for which services are being provided by the child support recovery unit, the child support recovery unit shall terminate an income withholding order previously entered by the unit when the current support obligation has terminated and when the delinquent support obligation has been fully satisfied as applicable to all of the children covered by the income withholding order. In no case shall payment of overdue support be the sole basis for termination of withholding.

- a. to d. Rescinded IAB 9/1/93, effective 11/1/93.

**98.44(3) *Other circumstances.*** The child support recovery unit may revoke an income withholding order under other circumstances provided the conditions of Iowa Code chapter 252D are met.

**441—98.45(252D) Modification of income withholding.** The child support recovery unit may modify a previously issued income withholding order or notice according to the guidelines established under rule 441—98.24(252D) if it is determined that:

**98.45(1) *Current support obligation changed.*** There has been a change in the amount of the current support obligation.

**98.45(2) *Amount in error.*** The amount required to be withheld under the income withholding order or notice is in error as follows:

- a. The amount required to be withheld as current support is not the amount specified in the order for support being enforced.
- b. The guidelines established in rule 441—98.24(252D) were not followed.

**98.45(3) *Past-due support paid.*** Any past-due support debt has been paid in full. The withholding order or notice shall be modified to require that only the current support obligation be withheld from the income of the obligor. Should a delinquency later accrue, the withholding order or notice may again be modified to secure an additional payment toward the delinquency. The amount of the arrears payment shall be set at 20 percent of the current support amount.

**98.45(4) *Income withholding and determination of controlling orders.*** An obligation amount different than what the child support recovery unit has been enforcing is established upon the determination of controlling order as allowed in Iowa Code section 252K.207. Upon the change to the new obligation amount, the amount withheld to be applied toward the liquidation of any delinquency shall be 20 percent.

**98.45(5) *Income withholding and review and adjustment of orders.*** The child support recovery unit has conducted a review of the obligation pursuant to 441—Chapter 99, Division IV. The unit shall modify the amount withheld to be applied toward the liquidation of any delinquency to 20 percent upon completion of the review and adjustment process.

**98.45(6) *Implementation or termination of amended amount of withholding due to hardship.*** The child support recovery unit has determined that the withholding order should be modified based upon the hardship provisions in rule 441—98.25(252D).  
[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.46(252D) Refunds of amounts improperly withheld.** The child support recovery unit shall refund to the obligor any amounts improperly withheld and received by the department under an income withholding order or notice issued by the unit, subject to the following:

**98.46(1) *Services provided by the department.*** Only those amounts received by the department during the period enforcement services are being provided are subject to refund.

**98.46(2) *Satisfaction of amount to withhold.*** No refund shall be made unless amounts have been collected which fully satisfy the amount specified in the income withholding order or notice for the withholding period during which income has been generated.

**98.46(3) *When issued.*** Any amounts received in excess of the amounts specified in the order or notice to withhold shall be issued to the obligor within 30 days of discovery by the child support recovery unit, unless the obligor requests in writing that these amounts be credited toward the delinquency or future child support. If there is a dispute regarding whether there is an overpayment, the obligor may request an informal conference by following the procedures set out in subparagraphs 98.43(2) “a”(3) through (7). This procedure shall not preclude the obligor from utilizing other civil remedies.

**98.46(4) *Recovery by department.*** The department may recover payments from the obligee in excess of those described in subrule 98.46(2) which have been received by the department and improperly forwarded to the obligee.  
[ARC 4112C, IAB 11/7/18, effective 2/15/19]

**441—98.47(96) Child support intercept of unemployment insurance benefits.** When the department of workforce development notifies the child support recovery unit that an individual who owes a child support obligation being enforced by the unit has been determined to be eligible for unemployment insurance benefits, the unit will enforce a child support obligation that is owed by an obligor but is not being met by intercept of unemployment insurance benefits. “Owed but not being met” means either current child support not being met or arrearages that are owed.

**98.47(1) *Withholding.*** The child support recovery unit shall intercept unemployment insurance benefits by initiating a withholding of income pursuant to Iowa Code chapter 252D and this division. The amount to be withheld through a withholding of unemployment insurance benefits shall not exceed the amount specified in 15 U.S.C. 1673(b).

**98.47(2) *Provision of receipt.*** A receipt of the payments intercepted through unemployment insurance benefits will be provided once a year, upon the obligor’s request to the child support recovery unit.

This rule is intended to implement Iowa Code section 96.3 and 15 U.S.C. 1673(b).  
[ARC 5417C, IAB 2/10/21, effective 4/1/21]

These rules are intended to implement Iowa Code Supplement chapters 252D and 252E.

**441—98.48 to 98.50** Reserved.

DIVISION III  
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

**441—98.51 to 98.60** Renumbered as 99.61 to 99.70, IAB 9/1/93, effective 11/1/93.

DIVISION IV  
PUBLICATION OF NAMES

**441—98.61(252B) List for publication.** The department may compile and make available for publication a list of cases in which no payment has been credited to an accrued or accruing support obligation during a previous three-month period, subject to the following:

**98.61(1) *Support order entered in Iowa.*** The list shall include cases with a support order entered in Iowa which is being enforced by the child support recovery unit.

**98.61(2) *Support order entered in another state.*** The list may include cases with a support order entered in another state, if another state has requested this service, has demonstrated that the provision of this service is not in conflict with the laws of the state where the support order is entered, and the order is being enforced by the child support recovery unit.

**98.61(3) *When compiled.*** The department shall determine when to compile the list, but shall not be required to do so.

**98.61(4) *Case selection.*** Case selection shall be based on the records of the department at the time the list is compiled. The three-month period of nonpayment shall end no earlier than one month prior to the date the list is compiled. When an obligor has multiple orders on a case, all orders contained in the child support recovery unit record may be listed.

**98.61(5) *Good cause.*** The name of the obligor shall not be included when there has been a finding of good cause for noncooperation with the child support recovery unit in a public assistance case pursuant to 441—subrule 41.2(8) or 441—subrule 75.14(1) and a determination has been made that enforcement may not proceed without risk of harm to the child or caretaker.

**441—98.62(252B) Releasing the list.** The department may release the information, no more than twice annually, as follows:

**98.62(1) *Release to media.*** The department shall issue a press release to the weekly and daily newspapers in Iowa describing the manner in which a copy of the list may be obtained. Cost of producing the list shall be borne by the department. Costs of producing and transmitting a copy of the list shall be borne by the recipient of the copy.

**98.62(2) *Availability of list.*** Once released, the list shall be provided to other persons upon payment of an amount to cover the cost of producing a copy as specified in 441—subrule 9.3(7). Requests shall be directed to the Bureau of Collections, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114.

These rules are intended to implement Iowa Code section 252B.9.

**441—98.63 to 98.70** Reserved.

DIVISION V  
ADMINISTRATIVE SEEK EMPLOYMENT ORDERS

**441—98.71(252B) Seek employment order.** The child support recovery unit (CSRU) may enter an ex parte order requiring the obligor to seek employment if employment of the obligor cannot be verified and if the obligor has failed to make support payments. Any obligor who has failed to make support payments and for whom employment cannot be verified is subject to issuance of an administrative order to seek employment.

**441—98.72(252B) Effective date of order.** The seek employment order shall be effective 15 days after issuance of the order to the obligor. This 15-day period shall serve as advance notice to the obligor.

**441—98.73(252B) Method and requirements of reporting.** The obligor shall complete Form 470-3155, Report of Seek Employment Activity, which shall be submitted to the unit on a weekly basis throughout the duration of the order unless the obligor has a valid reason for not complying with the

order. The obligor shall document at least five new attempts to find employment on the form each week. The same employer may not be reported more than once per week.

The obligor shall include the names, addresses, and the telephone numbers of each of the five employers or businesses with whom the obligor attempted to seek employment and the name of the individual contact to whom the obligor made application for employment or to whom the inquiry was directed.

**441—98.74(252B) Reasons for noncompliance.** Upon verification, certain conditions shall be considered valid reasons for noncompliance. At the request of the child support recovery unit (CSRU), the obligor shall provide verification of any reason for noncompliance with the order when the information is not available to CSRU through online sources. Valid reasons for noncompliance and acceptable verification are:

**98.74(1) Receipt of social security, supplemental security income (SSI), or the family investment program (FIP).** Receipt of social security, SSI, or FIP is considered a valid reason for noncompliance when verified by information contained in online sources available to CSRU or written verification from the agency providing the benefits.

**98.74(2) Temporary illness or disability.** Temporary illness or disability of the obligor or other household member is considered a valid reason upon receipt of completed Form 470-3158, Physician's Statement, verifying the obligor's inability to seek or accept employment.

**98.74(3) High school student.** Attending high school is considered a valid reason upon verification from the high school.

**98.74(4) Incarceration.** Incarceration is considered a valid reason when verified through online information available to CSRU or on receipt of verification from the institution.

**98.74(5) Substance abuse treatment.** Participating in a supervised substance abuse treatment program that is associated with a treatment center is considered a valid reason upon verification from the treatment center.

**98.74(6) Job training.** Participation in a job training or job seeking program through the department of employment services as a result of receiving food stamps is considered a valid reason upon receipt of verification from the department of employment services.

**98.74(7) Employment or self-employment.** Employment or self-employment is considered a valid reason upon verification through the employer for those employed or through tax documents or business records for those self-employed.

**98.74(8) Payment of support.** Payment on the account equal to the amounts prescribed for income withholding in accordance with rule 441—98.24(252D) throughout the duration of the seek employment order is considered a valid reason upon verification of payments posted to the Iowa collection and reporting (ICAR) system.

**441—98.75(252B) Method of service.** The seek employment order shall be served on the obligor by regular mail. Proof of service shall be completed in accordance with Iowa Rules of Civil Procedure, Number 82.

**441—98.76(252B) Duration of order.** The seek employment order shall remain in effect for three months from the date of issuance unless CSRU determines the obligor has a valid reason for noncompliance as specified at rule 441—98.74(252B), at which time the order becomes unenforceable.

Upon acceptance of the reason for noncompliance, CSRU shall notify the obligor that the obligor is no longer required to comply with the seek employment order. Upon denial of the reason for noncompliance, CSRU shall notify the obligor that the obligor shall comply with the existing seek employment order. The notice shall be filed with the clerk of the district court. If the obligor disputes this decision, the obligor shall have recourse through the district court.

These rules are intended to implement Iowa Code section 252B.21.

**441—98.77 to 98.80** Reserved.

DIVISION VI  
OFFSET**441—98.81(252B) Definitions.**

“*Delinquent support*” means a payment, or portion of a payment, including interest, not received by the clerk of the district court or other designated agency at the time it was due. In addition, delinquent support shall also include payments for parental liabilities not received as specified pursuant to rule 441—156.2(234).

“*Federal nontax payment*” means an amount payable by the federal government which is subject to administrative offset for support under the federal Debt Collection Improvement Act, Pub.L. No. 104-134.

“*Mistake of fact*” means a mistake in the identity of the obligor or whether the delinquency meets the criteria for referral.

This rule is intended to implement Iowa Code chapter 252B.  
[ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—98.82(252B) Offset against payment owed to a person by a state agency.** The department will make a claim against a payment owed to an obligor by a state agency when support payments are delinquent as set forth in rule 11—40.1(8A). A claim against a payment owed to an obligor shall be applied to court-ordered support which the department is attempting to collect pursuant to Iowa Code chapter 252B.

**98.82(1) Case selection.** The department shall submit to the department of administrative services, at least monthly, a list of obligors who are delinquent at least \$50 in support payments.

**98.82(2) Notification of offset.** Within ten days of receiving notification from the department of administrative services that the obligor is entitled to a payment, the department shall:

*a.* Send a preoffset notice to the obligor. The preoffset notice shall inform the obligor of the amount the department intends to claim and apply to the support obligation and shall contain all information required by Iowa Code subsection 8A.504(2) and 11—subrule 40.4(4).

*b.* Notify the department of administrative services that the preoffset notice has been sent to the obligor.

**98.82(3) Appeal process.** An obligor may contest the department’s claim by submitting a written request to the department. A hearing shall be granted pursuant to rules in 441—Chapter 7 if the obligor’s request is submitted within 15 days of the date of the preoffset notice. Except as specifically provided in this rule, administrative appeals will be governed by 441—Chapter 7. 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.

**98.82(4) Joint owner.** A joint owner’s proportionate share of the payment, as determined by the department, shall be released unless other claims are made on that portion of the payment. The department must receive a request for release of a joint owner’s share within 15 days of the date of the preoffset notice. The request may be made by either owner.

**98.82(5) Final disposition of offset.** The department shall notify an obligor of the final decision regarding the claim against the offset by sending a final disposition of support recovery claim notice to the obligor.

**98.82(6) Distribution of offset amount.** Offsets shall be applied in accordance with rules 441—95.3(252B) and 441—95.4(252B).

**98.82(7) Percentage of payment offset.** The amount of offset shall be 50 percent of the total payment due the obligor, unless the payment results from lottery winnings, from gambling winnings, from sports wagering winnings, or from a payment for a claim under treasurer of state rules on unclaimed property at 781—Chapter 9, in which case the amount of offset shall be 100 percent of the payment. The amount taken shall not exceed the delinquent amount owed by the obligor.

This rule is intended to implement Iowa Code sections 252B.3 and 252B.4 and Iowa Code subsection 8A.504(2).  
[ARC 9177B, IAB 11/3/10, effective 1/1/11; ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—98.83(252B) Offset against state income tax refund or rebate.** The department will make a claim against an obligor's state income tax refund or rebate when a support payment is delinquent as set forth in 11—Chapter 40. A claim against an obligor's state income tax refund or rebate shall apply to support which the department is attempting to collect.

**98.83(1)** By the first day of each month, the department shall submit to the department of administrative services a list of obligors who are delinquent at least \$50 in support payments.

**98.83(2)** When the department claims an obligor's state income tax refund or rebate, the department shall send a preoffset notice to the obligor to inform the obligor of the amount the department intends to claim and apply to support. The department shall send a preoffset notice when:

*a.* The department of administrative services notifies the department that the obligor is entitled to a state income tax refund or rebate; and

*b.* The obligor has a delinquency of \$50 or greater.

**98.83(3)** When the obligor wishes to contest a claim, a written request shall be submitted to the department within 15 days of the date of the preoffset notice. When the request is received within the 15-day limit, a hearing shall be granted pursuant to rules in 441—Chapter 7. Except as specifically provided in this rule, administrative appeals will be governed by 441—Chapter 7. 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.

**98.83(4)** The spouse's proportionate share of a joint return filed with an obligor, as determined by the department of revenue, shall be released by the department of revenue unless other claims are made on that portion of the joint income tax refund. The request for release of a spouse's proportionate share shall be received by the department within 15 days of the date of the preoffset notice.

**98.83(5)** The department shall refund any amount incorrectly offset to the obligor unless the obligor agrees in writing to apply the refund of the incorrect offset to any other support obligation due.

**98.83(6)** The department shall notify an obligor of the final decision regarding the claim against the tax refund or rebate by sending a final disposition of support recovery claim notice to the obligor.

**98.83(7)** Offsets shall be applied as provided in rule 441—95.3(252B).

This rule is intended to implement Iowa Code sections 8A.504, 252B.3, 252B.4 and 252B.5(4).  
[ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—98.84(252B) Offset against federal income tax refund and federal nontax payment.** The department will make a claim against an obligor's federal income tax refund or federal nontax payment when delinquent support is owed. For purposes of this offset, delinquent support shall include the entire balance of a judgment for accrued support, as provided in Iowa Code section 252B.5(4).

**98.84(1) Amount of assigned support.** If the delinquent support is assigned to the department, the amount of delinquent support shall be at least \$150, calculated by combining the assigned delinquent support in all of the obligor's cases in which the assigned delinquent support is at least \$50.

**98.84(2) Amount of nonassigned support.** If delinquent support is not assigned to the department, the claim shall be made if the amount of delinquent support is at least \$500, calculated by combining the nonassigned delinquent support in all of the obligor's cases in which the nonassigned delinquent support is at least \$50.

*a.* The amount distributed to an obligee shall be the amount remaining following payment of a support delinquency assigned to the department. The department shall distribute to an obligee the amount collected from an offset according to subrule 98.84(9) within the following time frames:

(1) Within six months from the date the department applies an offset amount from a joint income tax refund to the child support account of the responsible person, or within 15 days of the date of resolution of an appeal under subrule 98.84(8), whichever is later, or

(2) Within 30 days from the date the department applies an offset amount from a single income tax refund to the child support account of the responsible person, or within 15 days of the date of resolution of an appeal under subrule 98.84(8), whichever is later.

(3) However, the department is not required to distribute until it has received the amount collected from an offset from the federal Department of the Treasury.

b. Federal nontax payment offsets shall be applied as provided in rule 441—95.3(252B).

**98.84(3) Notification to federal agency.** The department shall, by October 1 of each year or at times as permitted or specified by federal regulations, submit a notification(s) of liability for delinquent support to the federal Office of Child Support Enforcement.

**98.84(4) Preoffset notice and review.** Each obligor who does not have an existing support debt on record with the federal Office of Child Support Enforcement will be sent a preoffset notice in writing, using address information provided to the federal Office of Child Support Enforcement, stating the amount of the delinquent support certified for offset.

a. Individuals whose names were submitted for federal offset who wish to dispute the offset must notify the department in writing within the time period specified in the preoffset notice.

b. Upon receipt of a complaint from the individual disputing the submission for offset, the child support recovery unit shall conduct a review to determine if there is a mistake of fact and respond to the individual in writing within ten days.

**98.84(5) Recalculation of delinquency.** When the records of the department differ with those of the obligor for determining the amount of the delinquent support, the obligor may provide and the department will accept documents verifying modifications of the order, and records of payments made pursuant to state law, and will recalculate the delinquency.

**98.84(6) Notification of modification or elimination.** The department shall notify the federal Office of Child Support Enforcement, within time frames established by the federal Office of Child Support Enforcement, of any modification or elimination of an amount referred for offset.

**98.84(7) Failure to timely respond.** When an individual does not respond to the preoffset notice within the specified time even though the department later agrees a certification error was made, the individual must wait for corrective action as specified in subrule 98.84(8).

**98.84(8) Offset notice, appeal, and refund.** The federal Department of the Treasury will send notice that a federal income tax refund or federal nontax payment owed to the obligor has been intercepted. When the unit receives information from the federal Office of Child Support Enforcement regarding the offset, or when the individual whose name was submitted for federal offset notifies the department that the individual has received an offset notice, the department shall issue to that individual Form 470-3684, Appeal Rights for Federal Offsets.

a. The individual whose name was submitted for federal offset shall have 15 days from the date of the notice to contest the offset by initiating an administrative appeal pursuant to 441—Chapter 7. Except as specifically provided in this rule, administrative appeals will be governed by 441—Chapter 7. 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.

b. The department shall refund the incorrect portion of a federal income tax offset or federal nontax payment offset within 30 days following verification of the offset amount. Verification shall mean a listing from the federal Office of Child Support Enforcement containing the obligor's name and the amount of tax refund or nontax payment to which the obligor is entitled. The date the department receives the federal listing will be the beginning day of the 30-day period in which to make a refund.

c. The department shall refund the amount incorrectly set off to the obligor unless the obligor agrees in writing to apply the refund of the incorrect offset to any other support obligation due.

**98.84(9) Application of offsets.** Offsets of federal income tax refunds shall be applied to delinquent support only. The department shall first apply the amount collected from an offset to delinquent support assigned to the department under Iowa Code chapters 234 and 239B. The department shall then apply any amount remaining in equal proportions to delinquent support due individuals receiving nonassistance services.

This rule is intended to implement Iowa Code sections 252B.3, 252B.4, and 252B.5.  
[ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—98.85 to 98.90** Reserved.

DIVISION VII  
ADMINISTRATIVE LEVY

**441—98.91(252I) Administrative levy.** When there is a delinquency in an amount equal to the ordered support payable for one month, the child support recovery unit may issue an administrative levy to the obligor's financial institution.

**441—98.92** Reserved.

**441—98.93(252I) Verification of accounts.** The unit may contact a financial institution to obtain verification of the account number, the names and social security numbers listed on the account, and the account balance for an obligor's account. This contact may be by telephone or written communication on Form 470-3170, Asset Verification Form, or by computer printout.

**441—98.94(252I) Notice to financial institution.** The unit may send a notice to the financial institution with which the account is placed, directing that the financial institution forward to the collection services center all or a portion of the moneys in the obligor's account or accounts on the date the notice is received. The notice shall be sent by first-class mail, with proof of service completed according to rule of civil procedure 82. The notice to the financial institution shall contain all of the information specified in Iowa Code chapter 252I.

**441—98.95(252I) Notice to support obligor.** The unit shall notify an obligor, and any other party known to have an interest in the account, of the action. The notice shall contain all of the information specified in Iowa Code chapter 252I. The unit shall forward the notice by first-class mail within two working days of sending the notice to the financial institution. Proof of service shall be completed according to Iowa Rules of Civil Procedure 82.

**441—98.96(252I) Responsibilities of financial institution.** Upon receipt of the notice of administrative levy, the financial institution shall follow procedures specified in Iowa Code section 252I.7 for encumbering and forwarding funds to collection services center. The financial institution shall encumber only the funds in the obligor's account on the day the notice is received. Any deposits made by the obligor after notice is received by the financial institution are not subject to the administrative levy process unless another notice is issued to the financial institution.

**441—98.97(252I) Challenging the administrative levy.** An obligor or an account holder of interest may challenge the administrative levy by submitting a written challenge to the person identified as the contact for the unit in the notice, within ten working days of the date of the notice to the obligor as specified in rule 441—98.95(252I). Upon receipt of a challenge, the unit shall follow criteria and procedures specified in Iowa Code section 252I.8 for resolving the challenge.

**98.97(1) Review of facts.** The unit shall, upon receipt of a written challenge, review the facts of the case with the challenging party. Only a mistake of fact including, but not limited to, a mistake in the identity of the obligor or a mistake in the amount of delinquent support due shall be considered as a reason to dismiss or modify the proceeding. If the unit determines that a mistake of fact has occurred, the unit shall proceed as follows:

*a.* If a mistake in identity has occurred or the obligor is not delinquent in an amount equal to the payment for one month, the unit shall notify the financial institution and the obligor that the administrative levy has been released.

*b.* If the amount of support due was incorrectly overstated, the unit shall notify the financial institution to release the excess moneys to the obligor and remit the remaining moneys.

**98.97(2) Refunds of amounts improperly held.** If a mistake of fact has occurred and money has already been forwarded from the financial institution, the unit shall proceed as follows:

*a.* If a mistake in identity has occurred or the obligor is not delinquent in an amount equal to the payment for one month, the unit shall refund the funds to the account and reimburse the account for any fees assessed by the financial institution.

*b.* If the amount of support due was incorrectly overstated, the unit shall refund a portion to the account. The unit is not required to reimburse the account for fees.

**98.97(3) Request for district court hearing.** If no mistake of fact is found, the unit shall send a notice to the challenging party by first-class mail. An obligor or an account holder may submit a second written challenge to the person identified as the contact for the unit in the notice, within ten working days of the date of the notice. The unit shall request a hearing before the district court in the county the support order is filed. Procedures for filing a hearing are specified in Iowa Code chapter 252I.

**98.97(4) Request for withdrawal.** The challenging party may withdraw the challenge by submitting a written withdrawal to the person identified as the contact person for the unit in the notice at any time prior to the court hearing. The unit may withdraw the administrative levy at any time prior to the court hearing. The unit shall provide notice of the withdrawal to the financial institution and any account holder of interest by first-class mail.

These rules are intended to implement Iowa Code chapter 252I.

**441—98.98 to 98.100** Reserved.

DIVISION VIII  
LICENSE SANCTION

**441—98.101(252J) Referral for license sanction.** In the process referred to as license sanction, the child support recovery unit (CSRU) may refer an individual to a licensing agency for the suspension, revocation, nonissuance, or nonrenewal of a variety of licenses including, but not limited to, motor vehicle registrations, driver's licenses, business and professional licenses, and licenses for hunting, fishing, boating, or other recreational activity. In order to be referred to a licensing agency for license sanction, one of the following must apply:

**98.101(1) Delinquent support payments.** An obligor's support payments must be delinquent in an amount equal to the support payment for three months. CSRU may first refer for license sanction those obligors having the greatest number of months of support delinquency. CSRU shall not refer obligors whose support payments are being made under an income withholding order.

**98.101(2) Subpoena or warrant.** An individual must have failed to comply with a subpoena or warrant, as defined in Iowa Code chapter 252J, relating to a paternity or support proceeding. If a subpoena was issued, the individual must have failed to comply with either Form 470-3413, Child Support Recovery Unit Subpoena, or an Interstate Subpoena as provided in paragraph 96.2(1) "a" within 15 days of the issuance of the subpoena, and proof of service of the subpoena was completed according to Rule of Civil Procedure 82.

**441—98.102(252J) Reasons for exemption.** Certain conditions shall be considered valid reasons for exemption from the license sanction process. Upon verification of these conditions, CSRU shall bypass, exempt, or withdraw the individual's name from referral to licensing agencies for the purpose of applying a license sanction. When the information to verify the exemption is not available to CSRU through online sources, CSRU shall request, and the individual shall provide, verification of the reason for exemption. Valid reasons for exemption for failure to comply with a subpoena or warrant and acceptable verification are those listed in subrules 98.102(2), 98.102(3), 98.102(5), and 98.102(6). Valid reasons for exemption for delinquent support payments and acceptable verification are any of the following:

**98.102(1) Receipt of social security, supplemental security income (SSI) or the family investment program (FIP).** Receipt of social security, SSI, FIP, or county assistance (general relief, general assistance, community services, veteran's assistance), based upon the eligibility of the obligor, is considered a valid reason for exemption when verified by information contained in online sources available to CSRU or written verification from the agency providing the benefits.

**98.102(2) *Temporary illness or disability.*** Temporary illness or disability of the individual or illness or disability of another household member which requires the presence of the individual in the home as caretaker is considered a valid reason for exemption upon receipt of a completed Form 470-3158, Physician's Statement, verifying the individual's or household member's inability to work.

**98.102(3) *Incarceration.*** Incarceration is considered a valid reason for exemption when verified through online information available to CSRU or upon receipt of verification from the institution.

**98.102(4) *Job training.*** Participation in a job-training or job-seeking program through the department of employment services as a result of receiving food stamps is considered a valid reason for exemption upon receipt of verification from the department of employment services or verification through online information available to CSRU or upon receipt of a written statement from an income maintenance worker.

**98.102(5) *Chemical dependency treatment.*** Participation in a chemical dependency treatment program that is licensed by the department of public health or the joint commission on the accreditation of hospitals (JCAH) is considered a valid reason for exemption upon receipt of written verification from the professional staff of the program that participation in the program precludes the individual from working.

**98.102(6) *Contempt process.*** Involvement in a contempt action dealing with support issues is considered a valid reason for exemption from the license sanction process during the pendency of the contempt action.

**441—98.103(252J) Notice of potential sanction of license.** When an individual meets the criteria for selection, CSRU may issue a notice to the individual of the potential sanction of any license held by the individual, using Form 470-3278, Official Notice of Potential License Sanction.

**98.103(1) *Delinquent support payments.*** CSRU shall inform the obligor that the obligor may make immediate payment of all current and past due child support, schedule a conference to review the action of CSRU, or request to enter into a payment agreement with the unit. CSRU shall follow the procedures and requirements of Iowa Code chapter 252J regarding the issuance of the notice and the holding of a conference.

**98.103(2) *Subpoena or warrant.*** CSRU shall inform the individual that the individual may comply with the subpoena or warrant, or schedule a conference to review the action of CSRU. CSRU shall follow the procedures and requirements of Iowa Code chapter 252J regarding the issuance of the notice and the holding of a conference.

**98.103(3) *Certificate of noncompliance.*** If an individual fails to respond in writing to the notice within 20 days, or if the individual requests a conference and fails to appear, the unit shall issue a Certificate of Noncompliance, Form 470-3274, to applicable licensing authorities in accordance with Iowa Code section 252J.3.

**441—98.104(252J) Conference.**

**98.104(1) *Scheduling of conference.*** Upon receipt from an individual of a written request for a conference, CSRU shall schedule a conference not more than 30 days in the future. At the request of either CSRU or the individual, the conference may be rescheduled one time. When setting the date and time of the conference, if notice was sent to an obligor under subrule 98.103(1), CSRU shall request the completion of Form 470-0204, Financial Statement, and other financial information from both the obligor and the obligee as may be necessary to determine the obligor's ability to comply with the support obligation.

**98.104(2) *Payment calculation.*** If notice was sent to an obligor under subrule 98.103(1) during the conference held in compliance with the provisions of Iowa Code section 252J.4, CSRU shall determine if the obligor's ability to pay varies from the current support order by applying the mandatory supreme court guidelines as contained in 441—Chapter 99, Division I, with the exception of subrules 99.4(3) and 99.5(5). If further information from the obligor is necessary for the calculation, CSRU may schedule an additional conference no less than ten days in the future in order to allow the obligor to present additional information as may be necessary to calculate the amount of the payment. If, at that time, the obligor fails

to provide the required information, CSRU shall issue a Certificate of Noncompliance, Form 470-3274, to applicable licensing authorities. If the obligee fails to provide the necessary information to complete the calculation, CSRU shall use whatever information is available. If no income information is available for the obligee, CSRU shall determine the obligee's income in accordance with 441—subrules 99.1(2) and 99.1(4). This calculation is for determining the amount of payment for the license sanction process only, and does not modify the amount of support obligation contained in the underlying court order.

**98.104(3) Referral for review and adjustment.** If the amount calculated in subrule 98.104(2) meets the criteria for review and adjustment as specified in rule 441—99.62(252B,252H), or administrative modification as specified in rule 441—99.82(252H) and subrules 441—99.83(1), 99.83(2) and 99.83(6) at the time CSRU provides the payment agreement to the obligor, CSRU shall also provide the obligor with any necessary forms to request a review and adjustment or administrative modification of the support obligation. The payment agreement remains in effect during the review and adjustment or administrative modification process.

**441—98.105(252J) Payment agreement.** The License Sanction Payment Agreement, Form 470-3273, shall require the obligor to pay the lower of the amount calculated in subrule 98.104(2) or the maximum amount payable under an income withholding order as specified in rule 441—98.24(252D).

**98.105(1) Duration of payment agreement.** The License Sanction Payment Agreement signed under this division shall remain in effect for at least one year from the date of issuance unless CSRU determines the obligor has a valid reason for exemption as specified in rule 98.102 (252J). Except in those cases in which review and adjustment are in process, CSRU may, at the end of the year, begin the process of reviewing the case to ensure that the payment amount continues to accurately reflect the obligor's ability to pay as calculated in subrule 98.104(1).

**98.105(2) Failure to comply.** If at any time following the signing of a payment agreement the obligor fails to comply with all the terms of the agreement, CSRU shall issue a Certificate of Noncompliance, Form 470-3274, to applicable licensing authorities in accordance with the provisions of Iowa Code chapter 252J.

**441—98.106(252J) Staying the process due to full payment of support.** If the obligor, at any time, pays the total support owed, both current and past due, or an individual complies with the subpoena or warrant, CSRU shall stay the process, and any Certificate of Noncompliance, Form 470-3274, which has been issued shall be withdrawn by CSRU.

**441—98.107(252J) Duration of license sanction.** The Certificate of Noncompliance, Form 470-3274, shall remain in effect until the obligor pays all support owed, both arrears and current; or the obligor enters into a payment agreement with CSRU; or the obligor meets one of the criteria for exemption specified at subrules 98.102(1), 98.102(2), and 98.102(4); or the individual complies with the subpoena or warrant.

These rules are intended to implement Iowa Code chapter 252J as amended by 1997 Iowa Acts, House File 612, division X.

**441—98.108 to 98.115** Reserved.

DIVISION IX  
CONSUMER REPORTING AGENCIES

**441—98.116(252B) Procedures for providing information to consumer reporting agencies.** The child support recovery unit shall make information available to consumer reporting agencies regarding the amount of delinquent support owed by a responsible person only in cases where the delinquent support exceeds \$1,000. However, before the unit will release the information to a consumer reporting agency, the agency must meet the requirements for a nationwide consumer reporting agency under Iowa Code section 252B.9(3)“j.”

**98.116(1) *Request of information.*** Agencies may request the information from the Bureau of Collections, Department of Human Services, 400 SW Eighth Street, Suite H, Des Moines, Iowa 50309-4691. Requests for information about an individual shall include the individual's name and identifying information such as a social security number or birth date. Agencies may also request a listing of all obligors owing support in excess of \$1,000.

**98.116(2) *Notice of proposed release of information.*** A notice of proposed release of information shall be sent to the last-known address of the responsible person 30 calendar days prior to the release of the support arrearage information to a consumer reporting agency. This notice shall explain the information to be released and the methods available for contesting the accuracy of the information.

**98.116(3) *Contesting proposed release of information.*** The responsible person may, within 15 calendar days of the date of the notice of proposed release of information, request a conference with the child support recovery officer to contest the accuracy of the information to be given to the consumer reporting agency. In contested cases no referral shall be made to the consumer reporting agency until after the amount of overdue support has been confirmed to exceed \$1,000.

This rule is intended to implement Iowa Code section 252B.9(3).  
[ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—98.117 to 98.120** Reserved.

DIVISION X  
EXTERNAL ENFORCEMENT

PREAMBLE

This division implements provisions of 1997 Iowa Acts, House File 612, sections 35 and 244, which provide for enforcement of child support arrearages by external sources. These sources are entities under contract to collect difficult-to-collect arrearages and private attorneys acting independently of the unit but with the unit's consent. The rules provide criteria and procedures for referral of delinquent support to collection contractors, assessment of the statutory surcharge, and opportunity for the delinquent parent to contest. The rules also provide a procedure to allow state payment to private attorneys enforcing child support recovery unit (CSRU) cases and provide criteria to exempt cases from the procedure.

**441—98.121(252B) *Difficult-to-collect arrearages.*** The child support recovery unit may refer difficult-to-collect arrearages to a collection entity under contract with the unit or with another state entity. Upon referral, a surcharge, in addition to the support, shall be due and payable by the obligor as provided in 1997 Iowa Acts, House File 612, section 244.

**98.121(1) *Difficult-to-collect arrearage.*** A difficult-to-collect arrearage is one based upon a court or administrative order which meets all the following criteria:

- a. There is no order for current support and only an arrearage is owing.
- b. There has been no payment, except for federal or state tax refund offset payments, in the past three months.
- c. There is no valid reason for exemption from the referral and surcharge process. Valid reasons for exemption and acceptable verification are those listed in subrules 98.102(1), 98.102(3), and 98.102(6). Upon verification of those conditions, the child support recovery unit shall bypass or exempt the obligor's arrearages from the referral and surcharge process. When the information to verify the exemption is not available to the child support recovery unit through online sources, the child support recovery unit shall request, and the obligor shall provide, verification of the reason for exemption.

**98.121(2) *Notice of the possibility of referral and surcharge.*** The child support recovery unit shall provide notice of the possibility of a referral and surcharge to the obligor as required by 1997 Iowa Acts, House File 612, section 244. The notice shall be provided at least 15 days before the unit sends the notice of referral and surcharge to the obligor, subject to the following:

*a. Notification contained in order.* When the support order under which the arrearage has accrued contains language advising of statutory provisions for referral and surcharge, no other preliminary notice shall be required.

*b. Notification issued by the child support recovery unit.* When the support order under which the arrearage has accrued does not contain language regarding the statutory provisions for referral and surcharge, or was entered under a foreign jurisdiction and notification was not included in the support order or provided as a separate written notice, the child support recovery unit shall issue a notice to the obligor. The notice shall be sent by regular mail to the obligor's last-known address.

**98.121(3) Notice of referral and surcharge.** The child support recovery unit shall send notice of a referral and surcharge to the obligor by regular mail to the obligor's last-known address, with proof of service completed according to Rule of Civil Procedure 82. The notice shall contain all the information required by 1997 Iowa Acts, House File 612, section 244. The notice shall be sent at least 30 days before the unit refers the arrearage to the collection entity.

**98.121(4) Contesting the referral and surcharge.** An obligor may contest the referral and surcharge. The right to contest is limited to a mistake of fact including but not limited to a mistake in the identity of the obligor, a mistake as to whether there was a payment in the three months before the date of the notice specified in subrule 98.121(3), a mistake as to whether an exemption in paragraph 98.121(1) "c" applies, or a mistake in the amount of arrearages.

*a.* An obligor may contest the referral and surcharge by submitting a written request for a review to the unit within 20 days of the date on the notice of referral and surcharge specified in subrule 98.121(3). Upon receipt of a written request for review, the unit shall follow the criteria and procedures specified in 1997 Iowa Acts, House File 612, section 244, for resolving the request.

(1) If the unit determines there is a mistake in the identity of the obligor, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.121(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, the unit shall issue a written notice to the contestant or obligor of the determination and not refer the arrearages. If the unit later determines an arrearage may be subject to referral, it shall issue a new notice as provided in subrule 98.121(3).

(2) If the unit determines there was a mistake in the amount of arrearages, but the corrected amount of arrearages will still be referred, or if the unit determines there is no mistake of fact, the unit shall issue a written notice of the determination of the review to the obligor by regular mail to the last-known address of the obligor. The notice shall include the amount of the arrearages that will be referred and the surcharge which will be assessed. The notice shall also include information on requesting an additional review by the bureau chief, and on requesting a judicial hearing. For purposes of this rule, bureau chief shall mean "bureau chief" as defined in rule 441—95.1(252B).

*b.* An obligor may contest the notice of determination of review by submitting a written request for an additional review by the bureau chief within 20 days of the date of the notice of determination of the review issued under paragraph "a." Upon receipt of the written request for additional review, the bureau chief shall review the facts of the case.

(1) If the bureau chief determines a mistake in the identity of the obligor has occurred, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.121(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, the bureau chief shall issue a written notice to the contestant or obligor of the determination and the arrearages shall not be referred. If the unit later determines an arrearage may be subject to referral, it shall issue a new notice as provided in subrule 98.121(3).

(2) If the bureau chief determines that there was a mistake in the amount of the arrearage but the corrected amount of arrearages will still be referred, or if there is no mistake of fact, the bureau chief shall send a written notice of the additional review determination to the obligor by regular mail to the last-known address of the obligor. The notice shall include the amount of the arrearage that will be referred and the surcharge which will be assessed. The notice shall also include information on requesting a judicial hearing.

c. Following the issuance of a notice of determination of a review under paragraph “a,” or issuance of a notice of determination of an additional review under paragraph “b,” the obligor may request a district court hearing. The obligor shall make a request by sending a written request for a hearing to the unit within ten days of the date of the unit’s written determination of the review, or within ten days of the date of the bureau chief’s written determination of an additional review, whichever is later. Procedures for a district court hearing are specified in 1997 Iowa Acts, House File 612, section 244.

d. The unit shall not refer arrearages and assess a surcharge until after completion of any review, additional review or judicial hearing process.

**98.121(5) Referral and surcharge.**

a. If the obligor has not paid the arrearage, has not contested the referral, or if, following the unit’s review, the bureau chief’s additional review, and any judicial hearing, the unit, bureau chief, or court does not find a mistake of fact, the arrearage shall be referred to the collection entity.

b. The amount of the arrearage referred shall be the amount that is unpaid as of the date of the referral. The amount of the surcharge shall be an amount equal to the amount of the arrearage unpaid as of the date of the referral, multiplied by the percentage specified in the contract with the collection entity.

c. The child support recovery unit shall file a notice of the surcharge with the clerk of the district court in the county in which the underlying support order is filed.

This rule is intended to implement 1997 Iowa Acts, House File 612, section 244.

[ARC 4576C, IAB 7/31/19, effective 9/4/19]

**441—98.122(252B) Enforcement services by private attorney entitled to state compensation.** An attorney licensed to practice law in Iowa may utilize judicial proceedings to collect support, at least a portion of which is assigned support, and be entitled to compensation by the state as provided in 1997 Iowa Acts, House File 612, section 35.

**98.122(1) Eligible cases.** To be eligible for attorney services with compensation under this rule, a case must meet all of the following:

a. The child support recovery unit is providing services under Iowa Code chapter 252B.

b. The current support obligation is terminated and only arrearages are due under the administrative or court order.

c. There has been no payment under any order in the case for at least a 12-month period prior to the provision of the notice from the attorney to the unit under paragraph “f.”

d. At least a portion of the arrearages due under any order in the case is assigned to the state because cash assistance was paid under 1997 Iowa Acts, Senate File 516, sections 2 through 24 and 35.

e. The case does not have any of the following characteristics:

(1) There has been a finding of good cause or other exception pursuant to Iowa Code section 252B.3 as amended by 1997 Iowa Acts, House File 612, section 26.

(2) A portion of the arrears is assigned to another state because of public assistance provided by that state.

(3) Another attorney has already notified the unit of the intent to initiate a judicial proceeding to collect support due under any order in the same case under this rule, and either the time to receive the collection has not expired or the unit has not received a notice from the other attorney that the judicial proceeding has concluded prior to the expiration of the time period.

(4) If the notice from the attorney under paragraph “f” specifies contempt of court as the judicial proceeding, and the unit has generated a seek employment order to the obligor under Iowa Code section 252B.21 less than nine months prior to the date on the notice from the attorney.

(5) The case or arrearages have been referred by the child support recovery unit to a collection entity under Iowa Code section 252B.5, subsection 3, as amended by 1997 Iowa Acts, House File 612, section 30, or 1997 Iowa Acts, House File 612, section 244, less than nine months prior to the date on the notice from the attorney.

(6) The obligor has filed for bankruptcy and collection activities are stayed.

(7) The notice from the attorney under paragraph “f” lists a specific judicial proceeding and the unit has already initiated the same type of proceeding in court.

(8) The case has been referred to the U.S. Attorney’s office and is still pending at that office.

*f.* The attorney has provided written notice to the central office of the child support recovery unit in Des Moines, as specified in subrule 98.122(2), and to the last-known address of the obligee of the intent to initiate a specified judicial proceeding to collect support on any identified court or administrative order involving the obligor and obligee in the case.

*g.* The attorney has provided documentation of insurance to the unit as required by 1997 Iowa Acts, House File 612, section 35.

*h.* The collection must be received by the collection services center within 90 days of the notice from the attorney in paragraph “f,” or within a subsequent 90-day extension period.

**98.122(2) Procedure.**

*a.* To begin the process under this rule, the attorney shall submit the following to the External Services Process Specialist, Bureau of Collections, Iowa Department of Human Services, Hoover Building, Fifth Floor, Des Moines, Iowa 50319-0114 at least 30 days prior to initiating the specified judicial proceeding:

(1) A dated, written statement which lists the specific judicial proceeding which the attorney intends to initiate, any court or administrative order under which the arrearages accrued identified by the order number, and the names of the obligor and obligee.

(2) Documentation that the attorney is insured as required by the statute. Documentation shall be either a copy of the attorney’s policy from the insurer, or a letter from the insurer verifying insurance coverage as required by the statute.

(3) Documentation that the attorney is licensed to practice law in Iowa.

*b.* The unit shall mail a response to the attorney within ten days of receipt of the notice from the attorney. All of the following shall apply to the unit’s response:

(1) If the case meets the requirements of this rule, the notice shall list the case number, any order numbers, the judicial proceeding specified by the attorney, the balance due the state of Iowa, the balance due an obligee, and the date that is 90 days from the date of the notice from the attorney. The notice shall also contain a statement that any compensation due the attorney as a result of application of this rule will be calculated on the amount of support credited to arrearages due the state at the time the support paid as a result of the judicial proceeding is received by the collection services center. The notice shall also contain a statement that any support collected shall be disbursed in accordance with federal requirements, and any support due the obligee shall be disbursed to the obligee prior to disbursement to the attorney as compensation.

(2) If the case does not meet the requirements of this rule, the notice shall list the case number, any order number, and the reason the case does not meet the requirements.

*c.* If the case is eligible under this rule, the attorney may initiate judicial proceedings after 30 days after providing the notice to child support recovery unit in paragraph “a.” Section 35 of 1997 Iowa Acts, House File 612, defines “judicial proceedings.”

*d.* The attorney may extend the time to complete the judicial proceeding or to allow for receipt of the collection by the collection services center by submitting a notice requesting a 90-day extension to the address in paragraph “a.” This or any subsequent notice must be received by the unit before expiration of the current 90-day time frame. The child support recovery unit shall acknowledge receipt of the subsequent notice and list on the acknowledgment the date that is 90 days from the date of the attorney’s subsequent notice.

**98.122(3) Collection and payment to attorney.**

*a.* Upon compliance with the requirements of 1997 Iowa Acts, House File 612, section 35, and this rule, the attorney shall be entitled to compensation from the state as provided for in this rule.

*b.* Upon receipt of a file-stamped copy of a court order which identifies the amount of support collected as a result of the judicial proceeding and which does not order the payment of attorney fees by the obligor, and the receipt of the collection by the collection services center, all the following apply:

(1) Section 35 of 1997 Iowa Acts, House File 612, specifies the formula to calculate the compensation due the attorney from the state. The child support recovery unit shall calculate the compensation due the attorney based upon the amount of support which is credited to arrearages due the state at the time the collection is received by the collection services center. After calculating the amount due the attorney, the unit shall reduce the amount due the attorney by the amount of any penalty or sanction imposed upon the state as a result of any other judicial proceeding initiated by that attorney under 1997 Iowa Acts, House File 612, section 35. The child support recovery unit shall send the attorney a notice of the amount of the compensation due from the state.

(2) The collection services center shall disburse any support due an obligee prior to payment of compensation to the attorney.

(3) The child support recovery unit shall not authorize disbursement of compensation to the attorney until the later of 30 days after receipt of the collection and the file-stamped copy of the order, or resolution of any timely appeal by the obligor or obligee.

(4) The amount of compensation due the attorney is subject to judicial review upon application to the court by the attorney.

This rule is intended to implement 1997 Iowa Acts, House File 612, section 35.

**441—98.123 to 98.130** Reserved

DIVISION XI  
APPEALS

**441—98.131(17A) Right of appeal.**

**98.131(1)** Under this chapter, an administrative appeal pursuant to 441—Chapter 7 shall be limited to the following issues:

*a.* A claim or offset is contested as provided in subrule 98.82(3), 98.83(3), or 98.84(8) by a person's alleging a mistake of fact.

*b.* A name has been certified for passport sanction as provided in Iowa Code section 252B.5.

**98.131(2)** A hearing shall not be granted under 441—Chapter 7 when the appellant has a complaint about child support recovery enforcement matters other than those described in this rule.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 5417C, IAB 2/10/21, effective 4/1/21]

**441—98.132(17A) Appeal record.** The record in an administrative appeal under this rule shall include, in addition to those materials specified in Iowa Code section 17A.12(6), the notice of appeal, all evidence received or considered and all other submissions, including the verbatim record of the hearing.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 5417C, IAB 2/10/21, effective 4/1/21]

These rules are intended to implement Iowa Code section 96.3 and chapter 252D.

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<sup>1</sup>See 2005 Iowa Acts, Senate File 350, section 20.

<sup>2</sup>See 2007 Iowa Acts, chapter 218, sections 186 and 187, and 2008 Iowa Acts, chapter 1019, section 18 (rule nullified effective July 1, 2009).

CHAPTER 99  
SUPPORT ESTABLISHMENT AND ADJUSTMENT SERVICES

PREAMBLE

This chapter contains rules governing the provision of services by the child support recovery unit regarding: the establishment of paternity; the establishment of support obligations in accordance with the mandatory guidelines set by the Iowa Supreme Court; the review and adjustment of support obligations; the modification of support obligations; and the suspension and reinstatement of support obligations. The rules in this chapter pertain only to administrative actions or procedures used by the unit in providing the services identified. This chapter shall not be interpreted to limit the unit's authority to use other means as provided for by state or federal statute, including, but not limited to, judicial procedures in providing these services.

DIVISION I  
CHILD SUPPORT GUIDELINES

**441—99.1(234,252B,252H) Income considered.** The child support recovery unit shall consider all regularly recurring income of both legal parents to determine the amount of the support award in accordance with the child support guidelines prescribed by the Iowa Supreme Court. These rules on child support guidelines shall not apply if the child support recovery unit is determining the support amount by a cost-of-living alteration as provided in Iowa Code chapter 252H, subchapter IV.

**99.1(1) Exempt income.** The following income of the parent is exempt in the establishment or modification of support:

- a. Income received by the parent under the family investment program (FIP).
- b. Income or other benefits derived from public assistance programs funded by a federal, state, or local governmental agency or entity that are listed in rule 441—41.27(239B) as exempt from consideration in determining eligibility under FIP.
- c. Income such as child support, social security dependent benefits received by a parent for a child because of the other parent's disability, and veteran's dependent benefits received by a parent on behalf of a child.
- d. Stepparent's income.
- e. Income of a guardian who is not the child's parent.
- f. Income of the child's siblings.
- g. Earned income tax credit.

**99.1(2) Determining income.** Any of the following may be used in determining a parent's income for establishing or modifying a support obligation:

- a. Income reported by the parent in a financial statement.
- b. Income established by any of the following:
  - (1) Income verified by an employer or other source of income.
  - (2) Income reported to the department of workforce development.
  - (3) For a public assistance recipient, income reported to the department of human services caseworker assigned to the public assistance case.
  - (4) Other written documentation that identifies income.
- c. Income as determined through occupational wage rate information published by the Iowa workforce development department or other state or federal agencies.
- d. The median income for parents on the CSRU caseload, calculated annually.
- e. Social security dependent benefits. Social security dependent benefits paid for a child because of a parent's disability shall be included in the disabled parent's income. Social security dependent benefits paid for a parent due to the other parent's disability shall be included in the receiving parent's income.

**99.1(3) Verification of income.** Verification of income and allowable deductions from each parent shall be requested.

a. Verification of income may include, but is not limited to, the following:

- (1) Federal and state income tax returns.
- (2) W-2 statements.
- (3) Pay stubs.
- (4) Signed statements from an employer or other source of income.
- (5) Self-employment bookkeeping records.
- (6) Award letters confirming entitlement to benefits under a program administered by a government or private agency such as social security, veterans' or unemployment benefits, military or civil service retirement or pension plans, or workers' compensation.

b. Cases in which the information or verification provided by a parent is questionable or inconsistent with other circumstances of the case may be investigated. If the investigation does not reveal any inconsistencies, the financial statement and other documentation provided by the parent shall be used to establish income.

c. If discrepancies exist in the financial statement provided by the parent and additional income information is not available, the child support recovery unit may:

- (1) Request a hearing before the court if attempting to establish a support order through administrative process.

- (2) Conduct discovery if a parent places the matter before the court by answering a petition or requesting a hearing before the court.

- (3) When attempting to establish a default order, provide the court with a copy of the parent's financial information and the reasons the information may be questionable.

d. If the child support recovery unit is unable to obtain verification of a parent's income, the financial statement provided by the parent may be used to establish support.

**99.1(4)** *Use of occupational wage rate information or median income for parents on the CSRU caseload.* Occupational wage rate information or median income for parents on the CSRU caseload shall be used to determine a parent's income when the parent has failed to return a completed financial statement when requested, and when complete and accurate income information from other readily available sources cannot be secured.

a. *Occupation known.* When the last-known occupation of a parent can be determined through a documented source including, but not limited to, Iowa workforce development or the National Directory of New Hires, occupational wage rate information shall be used to determine income. When the last-known occupation of a parent cannot be determined through a documented source, information may be gathered from the other parent and occupational wage rate information applied. Wage rate information shall be converted to a monthly amount in accordance with subrule 99.3(1).

b. *Occupation unknown.* When the occupation of a parent is unknown, CSRU shall estimate the income of a parent using the median income amount for parents on the CSRU caseload.

**99.1(5)** *Self-employment income.* A self-employed parent's adjusted gross income, rather than the net taxable income, shall be used in determining net income. The adjusted gross income shall be computed by deducting business expenses involving actual cash expenditures that affect the actual dollar income of the parent.

a. A person is 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 (IRS).

b. In calculating net income from self-employment, the child support recovery unit shall deduct only those items allowed by the child support guidelines. Amounts from a prior period claimed as net losses shall not be allowed as deductions.

c. Net profits from self-employment may be determined through a review of self-employment bookkeeping records, sales and expenditure records, quarterly reports filed with the IRS, previous year's federal or state income tax returns, or other documentation. The parent shall provide records of

bookkeeping, sales, and expenditures for the most recent 12-month period or, if the self-employment is less than 12 months old, for the period since the self-employment began.

**99.1(6) *Fluctuating income.*** A person has a fluctuating income when the calculated gross income or the adjusted gross income, as defined in subrule 99.1(5), for the current year varies from the gross or adjusted gross income of the previous year by more than 20 percent.

*a.* If requested, the child support recovery unit shall average the income of a person whose income fluctuated because the nature of the person's occupation is of a type that normally experiences fluctuations in income.

*b.* In determining a person's average income, the following procedures shall be used:

(1) For non-self-employed persons, the child support recovery unit shall estimate the gross income for the current year and add the amount to the gross income from relevant years that would accurately depict fluctuations in the person's income. The unit shall divide this sum by the number of years added, prior and current, to arrive at an average gross annual income. The unit shall divide the average gross annual income by 12 to arrive at the person's average gross monthly income.

(2) For income from self-employment, the child support recovery unit shall compute the adjusted gross annual income as defined in subrule 99.1(5) for the relevant years that would accurately depict fluctuations in the person's income. The unit shall use the adjusted gross annual income to compute the average adjusted gross monthly income in the same manner as the computation of average gross monthly income in 99.1(6) "b"(1).

**441—99.2(234,252B) Allowable deductions.** The deductions specified in the supreme court child support guidelines shall be allowed when determining the amount of income subject to application of the guidelines. The parent claiming the deduction shall provide the documentation necessary for computing allowable deductions. Allowable deductions are:

**99.2(1)** Federal and state income tax.

*a.* The child support recovery unit shall calculate the amount of the deduction for federal and state income tax as specified in the Iowa Supreme Court guidelines.

*b.* The unit shall calculate the amount of the deduction for self-employed persons with fluctuating incomes, as defined in subrule 99.1(6), by computing the person's averaged income and applying the method of calculating a tax deduction as required by Iowa Supreme Court guidelines.

**99.2(2)** Social security and Medicare tax deductions, mandatory pensions, and union dues as specified in the Iowa Supreme Court guidelines.

**99.2(3)** Mandatory occupational license fees as specified in the Iowa Supreme Court guidelines.

**99.2(4)** Actual payments of child and spousal support pursuant to a prior court or administrative order. The date of the original court or administrative order, rather than the date of any modifications, shall establish a prior order under this subrule. Support paid under an order established subsequent to the order being modified shall not be deducted. All support payments shall be verified before being allowed as a deduction. The child support recovery unit shall calculate deductions for support as follows:

*a.* In establishing prior support payments, the child support recovery unit shall verify payments made for the 12 months preceding the month in which the amount of support for the new order is determined. If the support obligation is less than one year old, the child support recovery unit shall verify each monthly payment since the beginning of the obligation.

*b.* If the obligation is one year old or older, the child support recovery unit shall add together all verified amounts paid during the past 12 months up to the total of the current support obligation that accrued during this 12-month period, and divide by 12. All amounts collected shall be included, regardless of the source.

*c.* If the support obligation is less than one year old, the child support recovery unit shall add together the verified amounts paid since the obligation began up to the total of the current support obligation that accrued during this period, and divide by the number of months that the obligation has existed.

*d.* When a parent has more than one prior support order, the child support recovery unit shall calculate the allowable deduction for each obligation separately, and then add the amounts together to determine the parent's total allowable deduction.

**99.2(5)** Actual medical support paid pursuant to a court order or administrative order in another order for other children, not the pending matter. All medical support payments shall be verified before being allowed as a deduction and shall be calculated in the same manner as the deductions for support in subrule 99.2(4).

**99.2(6)** Actual child care expenses during the custodial parent's employment, less the applicable federal income tax credit. The child support recovery unit shall determine the amount of the child care deduction as follows:

*a.* Actual child care expenses related to the custodial parent's employment shall be verified by a copy of the custodial parent's federal or state income tax return or by a signed statement from the person or agency providing the child care.

*b.* Only the amount of reported child care expenses in excess of the amount allowed as "credit for child and dependent care expenses" for federal income tax purposes shall be allowed as a deduction in determining the custodial parent's net income.

*c.* In determining the deduction allowed to the custodial parent for child care expenses due to employment, the following procedures shall be used:

(1) If the custodial parent provides a copy of a federal income tax return for the current tax processing year and the amount is consistent with the current financial circumstances of the parent, the child support recovery unit shall use the amount reported as "credit for child and dependent care expenses."

(2) If income tax information is not available, or if the parent indicates or there is reason to believe that the amount stated in the return is no longer representative of the parent's financial conditions or child care expenses, the child support recovery unit shall determine the allowable deduction for child care expenses for federal income tax purposes using the custodial parent's income only.

*d.* The child support recovery unit shall compute the child care deduction as follows:

(1) Divide the amount of child care expense the parent may claim as a deduction for federal income tax purposes by 12 to arrive at a monthly amount.

(2) If the child care expense reported on the financial statement is not a monthly amount, convert the reported amount to an equivalent monthly figure and round the figure to two decimal places.

(3) Subtract the amount the parent may claim as "credit for child and dependent care expenses" for federal income tax from the amount of child care expenses reported on the financial statement. The difference is the amount allowed for a deduction in determining income for child support.

**99.2(7)** Qualified additional dependent deduction (QADD). The qualified additional dependent deduction is the amount specified in the supreme court guidelines as a deduction for any child for whom parental responsibility has been legally established as defined by the child support guidelines. However, this deduction may not be used for a child for whom the parent may be eligible to take a deduction under subrule 99.2(4).

*a.* The deduction for qualified additional dependents may be used:

(1) For dependents of the custodial or noncustodial father or mother, whether in or out of the parent's home. The father may establish the deduction by providing written verification of a legal obligation to the children through one of the actions enumerated in the guidelines. The mother may establish the deduction by providing written verification of a legal obligation to the children, including the mother's statement.

(2) In the establishment of original orders.

(3) In the modification of existing orders. The deduction may be used in an upward modification. The deduction cannot be used to affect the threshold determination of eligibility for a downward modification, but may be used after the threshold determination is met.

*b.* Reserved.

**99.2(8)** Cash medical support as specified in the Iowa Supreme Court guidelines.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]

**441—99.3(234,252B) Determining net income.** Unless otherwise specified in these rules, the child support recovery unit shall determine net income as prescribed by the Iowa Supreme Court guidelines.

**99.3(1) *Calculating net income.*** All includable income and allowable deductions shall be expressed in monthly amounts. Income and corresponding deductions received at a frequency other than monthly shall be converted to equivalent monthly amounts by multiplying the income and corresponding deductions received on a weekly basis by 4.33, on a biweekly basis by 2.17, and on a semimonthly basis by 2.

**99.3(2) *Estimating net income.***

*a.* The estimated net income of a parent shall be 80 percent of the reported income or the estimated income as determined from occupational wage rate information or derived from the median income of parents on the CSRU caseload, as appropriate, minus the deductions enumerated in subrules 99.2(3) to 99.2(8) when the information to calculate these deductions is readily available through automated or other sources.

*b.* The net income of a parent shall be estimated under the following conditions:

(1) Gross earned income information was obtained from a source that did not provide itemized deductions allowed by the mandatory support guidelines.

(2) Occupational wage rate information or median income of parents on the CSRU caseload was used to determine a parent's income.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]

**441—99.4(234,252B) Applying the guidelines.**

**99.4(1) *Applying the guidelines.*** The child support recovery unit shall use the child support guidelines schedule as prescribed by the Iowa Supreme Court only for the number of children for whom support is being sought sharing the same two legal parents.

EXCEPTION: For foster care recovery cases, the guidelines schedule shall be used as set forth in subrule 99.5(4).

**99.4(2) *Establishing current support.***

*a. Calculation.* The child support recovery unit shall calculate the amount of support as prescribed by the Iowa Supreme Court guidelines. Round amount of support to the nearest whole dollar.

*b. Additional factors.*

(1) In all cases other than foster care, CSRU shall establish current support payable in monthly frequencies.

(2) In foster care cases, CSRU may establish current support payable in monthly or weekly frequencies. To establish a weekly amount, CSRU shall divide the figure in paragraph 99.4(2) "a" by 4.33 and round to the nearest whole dollar.

(3) If the court orders joint (equally shared) physical care of a child or split or divided physical care of multiple children, the unit shall calculate current support according to the Iowa Supreme Court guidelines for each parent assuming the other is the custodial parent. If a child begins receiving family investment program (FIP) benefits or if foster care funds are expended, an offset of the two amounts as a method of payment shall be disallowed.

(4) The amount of support shall be zero if the noncustodial parent's only income is Supplemental Security Income paid pursuant to 42 U.S.C. 1381a.

**99.4(3) *Establishing accrued support debt amount.***

*a.* Support debt created. The payment of public assistance to or for the benefit of a dependent child or a dependent child's caretaker creates an accrued support debt due and owing by the child's parent to the department. The amount of the accrued support debt is based on the period of time public assistance payment or foster care funds were expended, but is not created for the period of receipt of public assistance on the parent's own behalf for the benefit of the dependent child or the child's caretaker.

*b.* Calculating accrued support debt. CSRU shall calculate the accrued support debt as follows:

(1) For Family Investment Program (FIP) benefits, CSRU shall use the period for which FIP was paid during the 36 months preceding the date the notice of support debt is prepared or the date the petition is filed. For foster care assistance, CSRU shall use the three-month period for which foster care assistance

was paid prior to the date the initial notice to the noncustodial parent of the amount of support obligation is prepared, or the date a written request for a court hearing is received, whichever is earlier.

(2) CSRU shall exclude periods the noncustodial parent received public assistance as a part of this eligible group.

(3) CSRU may extend the period to include any additional periods public assistance is expended prior to the entry of the order.

(4) CSRU shall calculate the amount of the obligation by using the current net income of both parents, the guidelines in effect at the time the order is entered, and the number of children of the noncustodial parent who were receiving public assistance for each month for which accrued support is sought.

(5) CSRU shall calculate the total amount of the FIP support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount.

(6) CSRU may calculate the total amount of the foster care support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount and shall adjust this amount for weeks in which no foster care benefits were paid.

c. Establishing the accrued support repayment amount.

(1) In cases other than foster care, CSRU shall establish the repayment amount as follows:

1. When there is an ongoing obligation, the monthly repayment amount shall be 10 percent of the ongoing amount unless the noncustodial parent agrees to a higher amount.

2. When the order does not include ongoing support, the monthly repayment amount shall be the same as the amount for ongoing support which would have been due if such an obligation had been established. However, when all of the children for whom accrued support debt is sought are residing with the noncustodial parent, the monthly repayment amount shall be set at 10 percent of this amount.

(2) In foster care cases, CSRU shall establish the repayment amount in the same manner as subparagraph (1), but may establish weekly amounts and if the order does not include ongoing support, the repayment amount shall be set at 10 percent of the amount for ongoing support which would have been due if such an obligation had been established.

**99.4(4) *Children in nonparental homes or foster care.*** The parents of a child in a nonparental home or in foster care are severally liable for the support of the child. A support obligation shall be established separately for each parent.

a. Parents' location known. When the location is known for both parents having a legal obligation to provide support for their children, the income of both parents shall be used to determine the amount of ongoing support in accordance with the child support guidelines.

(1) Calculating support amount. There shall be a separate calculation of each parent's child support amount, regardless of whether the parents are married and living together, or living separately. Each calculation shall assume that the parent for whom support is being calculated is the noncustodial parent and the other parent is the custodial parent.

(2) Prior orders. If only one parent is paying support under a prior order for the children for whom support is being calculated, the amount of support paid shall not be deducted from that parent's net monthly income in computing the support amount for the other parent.

b. One parent's location unknown. When the location of one parent is not known, procedures shall be initiated to establish a support order against the parent whose location is known in accordance with the mandatory support guidelines as follows:

(1) The parent whose location is known shall be considered the noncustodial parent and that parent's income shall be used to calculate child support.

(2) The income of the parent whose location is unknown shall be determined by using the estimated median income for parents on the CSRU caseload and that parent shall be considered the custodial parent in calculating child support.

c. When one parent is deceased or has had parental rights terminated, the method used to calculate support when one parent's location is not known shall be used. The parent who is deceased or has had parental rights terminated shall be considered the custodial parent with zero income.

**99.4(5) *Extraordinary visitation adjustment.*** The extraordinary visitation adjustment is a credit as specified in the supreme court guidelines. The credit shall not reduce the child support below the amount required by the supreme court guidelines.

The extraordinary visitation adjustment credit shall be given if all of the following apply:

*a.* There is an existing order for the noncustodial parent that meets the criteria for extraordinary visitation in excess of 127 overnights per year on an annual basis for the child for whom support is sought. The order granting visitation can be a different order than the child support order. If a controlling order is determined pursuant to Iowa Code chapter 252K and that controlling support order does not meet the criteria for extraordinary visitation, there is another order that meets the criteria.

*b.* The noncustodial parent has provided CSRU with a file-stamped or certified copy of the order.

*c.* The court has not ordered equally shared physical care.

**99.4(6) *Establishing medical support.*** The child support recovery unit shall calculate medical support as required by Iowa Code chapter 252E and the Iowa Supreme Court guidelines. The cost of the health insurance premium for the child is added to the basic support obligation and prorated between the parents as provided in the Iowa Supreme Court guidelines, and the parent ordered to provide health insurance must provide verification of this expense or anticipated expense.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]

#### **441—99.5(234,252B) Deviation from guidelines.**

**99.5(1) *Criteria for deviation.*** The court shall not vary from the amount of child support that would result from application of the guidelines without a written finding as required by the Iowa Supreme Court guidelines.

**99.5(2) *Supporting financial and legal documentation.***

*a.* The party requesting a deviation from the guidelines shall provide supporting documentation. The supporting documentation shall include an itemized list identifying the amount and nature of each adjustment requested. Failure to provide supporting documentation for a request for deviation shall result in a denial of the request.

*b.* Legal documents prepared for the court's approval, such as stipulations and orders for support, shall include language to identify the following:

(1) The amount of support calculated under the guidelines without allowance for deviations.

(2) The reasons for deviating from the guidelines.

(3) The amount of support calculated after allowing for the deviation.

**99.5(3) *Depreciation.*** A parent may request a deduction for depreciation of machinery, equipment, or other property used to earn income. Straight-line depreciation shall be the only type of depreciation that shall be allowed as a deduction. The child support recovery unit shall allow the straight-line depreciation amount as a deduction if the parent provides documentation from a tax preparer verifying the amount of straight-line depreciation being claimed. Straight-line depreciation is computed by deducting the property's estimated salvage value from the cost of the property, and deducting that figure in equal yearly amounts over the period of the property's remaining estimated useful life.

**99.5(4) *Foster care case.*** In a foster care case, the child support recovery unit may deviate from the guidelines by applying a 30 percent flat rate deduction for parents who provide financial documentation. The flat rate deduction represents expenses under the case permanency plan and financial hardship allowances or other circumstances contemplated in Iowa Code section 234.39.

CSRU shall calculate the support obligation of the parents of children in foster care when the parents have a legal obligation for additional dependents in the home, as follows: The support obligation of each parent shall be calculated by allowing all deductions the parent is eligible for under the child support guidelines as provided in rule 441—99.2(234,252B) and by using the guidelines schedule corresponding to the sum of the children in the home for whom the parent has a legal obligation and the children in foster care. The calculated support amount shall be divided by the total number of children in foster care and in the home to compute the support obligation of the parent for each child in foster care.

**99.5(5) *Negotiation of accrued support debt.*** The child support recovery unit may negotiate with a parent to establish the amount of accrued support debt owed to the department. In negotiating accrued

support, the state does not represent the custodial parent. The custodial parent may intervene at any time prior to the filing of the order to contest the amount of the debt or request the entry of a judgment in the parent's behalf which may otherwise be relinquished through negotiation or entry of a judgment.  
[ARC 1357C, IAB 3/5/14, effective 5/1/14]

These rules are intended to implement Iowa Code sections 234.39, 252B.3, 252B.5, 252B.7A, and 598.21(4).

**441—99.6 to 99.9** Reserved.

DIVISION II  
PATERNITY ESTABLISHMENT  
PART A  
JUDICIAL PATERNITY ESTABLISHMENT

**441—99.10(252A) Temporary support.** If a court ordered a putative father to pay temporary support before entering an order making a final determination of paternity under Iowa Code section 252A.6A, but then the court determines that the putative father is not the legal father and enters an order terminating the temporary support, all the following apply.

**99.10(1) Satisfaction of accrued support.** Upon receipt of a file-stamped copy of the order terminating the support order, the child support recovery unit shall take the following action concerning unpaid support assigned to the department:

- a. The child support recovery unit shall satisfy only unpaid support assigned to the department.
- b. The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver or notice, the child support recovery unit is not prevented from satisfying amounts due the department.
- c. The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate district court.

**99.10(2) Previously collected moneys.** The child support recovery unit shall not return any moneys previously paid on the temporary support judgment.

This rule is intended to implement Iowa Code section 252A.6A.

**441—99.11 to 99.20** Reserved.

PART B  
ADMINISTRATIVE PATERNITY ESTABLISHMENT

**441—99.21(252F) When paternity may be established administratively.** The child support recovery unit may seek to administratively establish paternity and accrued or accruing child support and medical support obligations against an alleged father when the conditions specified in Iowa Code chapter 252F are met.

**441—99.22(252F) Mother's certified statement.** Before initiating an action under Iowa Code chapter 252F, the unit may obtain a signed Child Support Information, Form 470-3877, or Establishment Questionnaire, Form 470-3929, or a similar document from the child's caretaker. The unit shall obtain the Mother's Written Statement Alleging Paternity, Form 470-3293, from the child's mother certifying, in accordance with Iowa Code section 622.1, that the man named is or may be the child's biological father. Government records, including but not limited to an application for public assistance, which substantially meet the requirements of Iowa Code section 622.1 may also be used. In signing Form 470-3293, the mother acknowledges that the unit may initiate a paternity action against the alleged father, and she agrees to accept service of all notices and other documents related to that action by first-class mail. The mother shall sign and return Form 470-3293 to the unit within ten days of the date of the unit's request.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]

**441—99.23(252F) Notice of alleged paternity and support debt.** Following receipt of the Mother's Written Statement Alleging Paternity, Form 470-3293, or government records, including but not limited to an application for public assistance, which substantially meet the requirements of Iowa Code section 622.1, the unit shall serve a notice of alleged paternity and support debt as provided in Iowa Code section 252F.3.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]

**441—99.24(252F) Conference to discuss paternity and support issues.** The alleged father may request a conference as provided in Iowa Code section 252F.3, subsection (1), with the office that issued the notice to discuss paternity establishment and the amount of support he may be required to pay.

**441—99.25(252F) Amount of support obligation.** The unit shall determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252B.7A.

**441—99.26(252F) Court hearing.** Rescinded ARC 5417C, IAB 2/10/21, effective 4/1/21.

**441—99.27(252F) Paternity contested.** The alleged father may contest the paternity establishment by submitting, within 20 calendar days after service of the notice upon him, as provided in rule 441—99.23(252F), a written statement contesting paternity to the address of the unit as set forth in the notice. The mother may contest paternity establishment by submitting, within 20 calendar days after the unit mailed her notice of the action or within 20 calendar days after the alleged father is served with the original notice, whichever is later, a written statement contesting paternity to the address of the unit as set forth in the notice. When paternity is contested, or at the unit's initiative, the unit shall issue ex parte administrative orders requiring the alleged father, the mother and the child to submit to paternity testing. If the mother and child or children previously submitted blood or genetic specimens in a prior action to establish paternity against a different alleged father, the previously submitted specimens and prior results, if available, may be used for testing in this action.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.28(252F) Paternity test results challenge.** Either party or the unit may challenge the results of the paternity test by filing a written notice with the district court within 20 calendar days after the unit issues or mails the paternity test results to the parties. When a party challenges the paternity test results, and requests an additional paternity test, the unit shall order an additional blood or genetic test, if the party requesting the additional test pays for the additional testing in advance. If the party challenges the first paternity test results, but does not request additional tests, the unit may order additional blood or genetic tests.

**441—99.29(252F) Agreement to entry of paternity and support order.** If the alleged father admits paternity and reaches agreement with the unit on the entry of an order for support, the father may acknowledge his consent on the Child Support Declaration, Form 470-4084. If the mother does not contest paternity within the allowed time period or if the mother waives the time period for contesting paternity, the unit may file the Child Support Declaration, if applicable, and Administrative Paternity Order with the court in accordance with Iowa Code section 252F.6.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]

**441—99.30(252F) Entry of order establishing paternity only.** If the alleged father requests a court hearing on support issues and paternity is not contested, or if paternity was contested but neither party filed a timely challenge of the paternity test results, the unit shall prepare an order establishing paternity and reserving the support issues for determination by the court. The unit shall present the order and other documents supporting the entry of the ex parte paternity-only order to the court for review and approval prior to the hearing on the support issues.

**441—99.31(252F) Exception to time limit.** The unit may accept and respond to written requests for court hearings beyond the time limits allowed in this part.

**441—99.32(252F) Genetic test costs assessed.**

**99.32(1) *Paternity established.*** If genetic testing of an alleged father is conducted and that man is established as the child's father, the unit shall assess the costs of the genetic testing to the father who denied paternity and enter an order for repayment of these costs.

**99.32(2) *Paternity not established.*** If genetic testing of an alleged father is conducted and that man is not established as the child's father, the costs of the genetic testing shall not be assessed to any of the parties.

**99.32(3) *Results contested.*** If the results of the genetic testing are timely challenged and the challenging party requests additional testing, the party contesting the results shall advance the cost of the additional testing. If the challenging party does not advance payment for the additional testing, the unit shall certify the case to district court.

These rules are intended to implement Iowa Code chapter 252F.

**441—99.33 to 99.35** Reserved.

PART C  
PATERNITY DISESTABLISHMENT

**441—99.36(598,600B) Definitions.**

*"Disestablishment"* means paternity which is legally overcome under the conditions specified in Iowa Code section 600B.41A or section 598.21, subsection 4A.

*"Nonrequesting parent"* means a parent who is not filing a petition to overcome paternity.

*"Requesting parent"* means a parent who files a petition to overcome paternity.

**441—99.37(598,600B) Communication between parents.** When a parent who has filed a petition to disestablish paternity requests assistance from the child support recovery unit in contacting the other parent, the child support recovery unit shall take the following actions if services are being provided by the child support recovery unit, the location of the nonrequesting party is known, and the child support recovery unit has been provided a copy of the petition to disestablish paternity.

**99.37(1) *Written contact.*** The child support recovery unit shall send written notification to the nonrequesting parent of the requesting parent's desire to disestablish paternity and of the requesting parent's whereabouts. The notice shall state that the nonrequesting parent may cooperate in this action by filing a statement of the nonrequesting parent's current address or the name and address of the nonrequesting parent's attorney in the court file, or may contact the requesting parent with this information.

**99.37(2) *Notification of requesting parent.*** The child support recovery unit shall provide notification to the requesting party that contact was made with the nonrequesting party and that the nonrequesting parent may file a statement in the court file or may contact the requesting parent directly.

**441—99.38(598,600B) Continuation of enforcement.** The child support recovery unit shall continue all enforcement actions to collect current and accrued support as ordered until the unit receives a file-stamped copy of the order disestablishing paternity.

**441—99.39(598,600B) Satisfaction of accrued support.**

**99.39(1) *Disestablishment orders entered before May 21, 1997.*** Upon receipt of a file-stamped copy of an order disestablishing paternity which was entered before May 21, 1997, the child support recovery unit shall take the following action concerning unpaid support assigned to the department.

*a.* The child support recovery unit shall satisfy only unpaid support assigned to the department and only if:

(1) For actions under Iowa Code section 600B.41A, blood or genetic testing was done and a guardian ad litem was appointed for the child.

(2) For actions under Iowa Code section 598.21, the written statement was filed and a guardian ad litem was appointed for the child.

*b.* The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, the child support recovery unit is not prevented from satisfying amounts due the department.

*c.* The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate district court. If the court later determines that paternity was incorrectly disestablished, the child support recovery unit may attempt to reinstate and enforce the prior judgment.

**99.39(2)** *Disestablishment orders entered on or after May 21, 1997.* Upon receipt of a file-stamped copy of an order disestablishing paternity which was entered on or after May 21, 1997, the child support recovery unit shall take the following action concerning unpaid support:

*a.* If the order also contains a provision satisfying unpaid support, the unit shall adjust its records to show unpaid support is paid.

*b.* If the order does not contain a provision satisfying unpaid support, the unit shall satisfy only unpaid support assigned to the department. The unit shall notify the party who petitioned the court for disestablishment that this is the only support the unit can satisfy.

(1) The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver notice, the child support recovery unit is not prevented from satisfying amounts due the department.

(2) The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate court. If the court later determines that paternity was incorrectly disestablished, the child support recovery unit may attempt to reinstate and enforce the prior judgment.

**99.39(3)** *Termination of paternity.* If the court entered an order dismissing a disestablishment of paternity action on or before May 21, 1997, this subrule applies. Upon receipt of a file-stamped copy of an order terminating paternity under the requirements of Iowa Code section 600B.41A, the child support recovery unit shall take the following action concerning unpaid support assigned to the department:

*a.* The child support recovery unit shall satisfy only unpaid support assigned to the department.

*b.* The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, the child support recovery unit is not prevented from satisfying amounts due the department.

*c.* The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate district court. If the court later determines that paternity was incorrectly terminated, the child support recovery unit may attempt to reinstate and enforce the prior judgment.

**99.39(4)** *Previously collected moneys.* The child support recovery unit shall not return any moneys previously paid on the judgment.

These rules are intended to implement Iowa Code section 598.21, subsection 4A, and Iowa Code section 600B.41A.

**441—99.40** Reserved.

DIVISION III  
ADMINISTRATIVE ESTABLISHMENT OF SUPPORT  
[Prior to 9/1/93, see 441—95.11(252C)]

**441—99.41(252C) Establishment of an administrative order.**

**99.41(1)** *When order may be established.* The bureau chief may establish a child or medical support obligation against a responsible person through the administrative process. This does not preclude the child support recovery unit from pursuing the establishment of an ongoing support obligation through other available legal proceedings. When gathering information to establish a support order, the unit may obtain a signed Child Support Information, Form 470-3877, or Establishment Questionnaire, Form 470-3929, or a similar document from the child's caretaker.

**99.41(2)** *Support debt.* When public assistance is paid to or Medicaid is received by a child of the responsible person, or the dependent child's caretaker, a support debt is created and owed to the department. When no public assistance is paid or Medicaid is received, the debt is owed to the individual caretaker.

**99.41(3)** *Notice to responsible person.* When the bureau chief establishes a support debt against a responsible person, a notice of child support debt shall be served in accordance with the Iowa Rules of Civil Procedure or Iowa Code section 252B.26. The notice shall include all of the rights and responsibilities shown in Iowa Code section 252C.3. The notice shall also inform the responsible person which of these rights may be waived pursuant to Iowa Code section 252C.12, and the procedures for and effect of waiving these rights. The notice shall include a statement that failure to respond within the time limits given and to provide information and verification of financial circumstances shall result in the entry of a default judgment for support.

**99.41(4)** *Negotiation conference.* The responsible person may, within ten calendar days after being served the notice of child support debt, request a negotiation conference with the office of the child support recovery unit which sent the notice.

**99.41(5)** *Amount of support obligation.* The child support recovery unit shall determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252B.7A.

*a.* Any deviation from the guidelines shall require a written finding by the bureau chief.

*b.* Reserved.

**99.41(6)** Reserved.

**99.41(7)** *Court hearing.* Either the responsible person or the child support recovery unit may request a court hearing regarding the establishment of a support obligation through the administrative process.

*a.* The request for a hearing by the responsible person shall be in writing and sent to the office of the child support recovery unit which sent the original notice of the support debt by the latest of the following:

(1) Thirty days from the date of service of the first notice of support debt.

(2) Ten days from the date of the negotiation conference.

(3) Thirty days from the date the second notice and finding of financial responsibility is issued.

(4) Ten days from the date of issuance of the conference report if the bureau chief does not issue a second notice and finding of financial responsibility after a conference was requested.

*b.* When a request for a court hearing is received from the responsible person, within the time limits allowed, or is made by the child support recovery unit, the bureau chief shall schedule or request that the hearing be scheduled in the district court in the county:

(1) Where the dependent child resides if the child resides in Iowa.

(2) Where the responsible person resides if the child for whom support is sought resides in another state or the sole purpose of the administrative order is to secure a judgment for the time period that public assistance was expended by the state on behalf of the family or child.

**99.41(8)** *Exception to time limit.* The bureau chief may accept and respond to written requests for a court hearing beyond the time limits allowed in this rule.

**99.41(9) Entry of order.** If no request for a hearing is received from the responsible person at the local office of the child support recovery unit, or made by the unit, the bureau chief may prepare an order for support and have it presented ex parte to the court for approval.

*a.* The attorney for the child support recovery unit shall present the order and other documents supporting the entry of the ex parte order to the court for review and approval. Pursuant to Iowa Code chapter 252C, the court shall approve the order unless defects appear in the order or supporting documents.

*b.* The bureau chief shall file a copy of the approved order with the clerk of the district court.

*c.* The bureau chief shall send a copy of the filed order by regular mail, to the caretaker's last-known address, to the responsible person's last-known address or the caretaker's or the responsible person's attorney pursuant to the provisions of Iowa Code chapter 252C within 14 days after approval and issuance of the order by the court.

**99.41(10) Force and effect.** Once the order has been signed by the judge and filed, it shall have all the force and effect of an order or decree entered by the court. Unless otherwise specified, the effective date of the support obligation shall be the twentieth day following the date the order is prepared by the unit.

**99.41(11) Modification by bureau chief.** The bureau chief may petition an appropriate court for modification of a court order on the same grounds as a party to the court order can petition the court for modification.

This rule is intended to implement Iowa Code chapter 252C.  
[ARC 1357C, IAB 3/5/14, effective 5/1/14]

**441—99.42 to 99.60** Reserved.

DIVISION IV  
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS  
[Prior to 9/1/93, see 441—98.51(73GA,ch1244) to 98.60(73GA,ch1244)]

**441—99.61(252B,252H) Definitions.**

*"Guidelines"* means the most current guidelines and criteria prescribed by the Iowa Supreme Court for determining the amount of child support to be awarded.

*"Parent"* means a person who is a responsible person or a caretaker, as those terms are defined in rule 441—95.1(252B).

*"Recipient of service"* means a person receiving foster care services, or a recipient of family investment program assistance or Medicaid benefits whose child support or medical support is assigned, or a person who is not receiving public assistance but who is entitled to child support enforcement services pursuant to Iowa Code section 252B.4.

**441—99.62(252B,252H) Review of permanent child support obligations.** Permanent child support obligations that are ongoing and being enforced by the child support recovery unit or the child support agency of another state shall be reviewed by the unit to determine whether or not to adjust the obligation. The unit shall determine the appropriate obligation amount using the child support guidelines. Iowa must have continuing, exclusive jurisdiction to modify the order under Iowa Code chapter 252K.

**99.62(1) Periodic review.** A permanent child support obligation being enforced by the child support recovery unit and meeting the conditions in Iowa Code section 252H.12 may be reviewed upon the initiative of the unit if:

*a.* The right to any ongoing child support obligation is currently assigned to the state due to the receipt of public assistance.

*b.* The support order does not already contain medical support provisions.

*c.* A review is otherwise necessary to comply with state or federal law.

**99.62(2) Review by request.** A review shall be conducted upon the request of the child support recovery agency of another state or upon the written request of either parent subject to the order submitted on Form 470-2749, Request to Modify a Child Support Order. One review may be conducted every two

years when the review is being conducted at the request of either parent. The request for review may be no earlier than two years from the filing date of the support order or most recent modification or the last completed review, whichever is later.

**99.62(3) Review outcome.**

*a.* Procedures to adjust the support obligation shall be initiated only when the financial and other information available to the child support recovery unit indicates that the:

(1) Present child support obligation varies from the Iowa Supreme Court mandatory child support guidelines by more than 20 percent, and

(2) Variation is due to a change in financial circumstances which has lasted at least three months and can reasonably be expected to last for an additional three months.

*b.* Procedures to modify a support order may be initiated when the order does not include provisions for medical support.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

**441—99.63(252B,252H) Notice requirements.** The child support recovery unit shall provide written notification to each parent affected by a permanent child support obligation being enforced by the child support recovery unit as follows:

**99.63(1) Notice of right to request review.** The child support recovery unit shall notify each parent of the right to request review of the order and the appropriate place and manner in which the request should be made. Notification shall be provided on Form 470-0188, Application For Nonassistance Support Services, or Form 470-1981, Notice of Continued Support Services, or through another printed or electronic format.

**99.63(2) Notice of review.** One of the following shall apply:

*a.* At least 15 days before the review is conducted, the child support recovery unit shall serve notice of its intent to review the order on each parent affected by the child support obligation. This notice shall include a request that the parties complete a financial statement and provide verification of income. The notice shall be served in accordance with Iowa Code section 252B.26 or 252H.15.

*b.* If the conditions of Iowa Code section 252H.14A(1) are met, the unit may conduct a review using information accessible to the unit without:

- (1) Issuing a notice under paragraph 99.63(2) “a,” or
- (2) Requesting additional information from the parent.

**99.63(3) Notice of decision.** After the child support recovery unit completes the review of the child support obligation in accordance with rule 441—99.62(252B,252H), the unit shall issue a notice of decision in accordance with Iowa Code section 252H.14A or 252H.16 stating whether or not an adjustment is appropriate and, if so, the unit’s intent to enter an administrative order for adjustment.

*a. and b.* Rescinded IAB 2/5/03, effective 4/1/03.

**99.63(4) Challenges to outcome of review.** Each parent shall be allowed to request a second review challenging the determination of the child support recovery unit. The procedure for challenging the determination is as follows:

*a.* The parent challenging the determination shall submit the request for a second review in writing to the child support recovery unit stating the reasons for the request and providing written evidence necessary to support the challenge. The request must be submitted:

(1) Within 10 days from the date of a notice of decision issued pursuant to Iowa Code section 252H.16, or

(2) Within 30 days from service of a notice of decision issued pursuant to Iowa Code section 252H.14A.

*b.* The child support recovery unit shall review the written evidence submitted with the request and all financial information available to the unit and make a determination of one of the following:

- (1) Rescinded IAB 2/5/03, effective 4/1/03.
- (2) To enter an administrative order for adjustment of the obligation.
- (3) That adjustment of the child support obligation is inappropriate.

c. The unit shall send written notice of the outcome of the second review to each parent affected by the child support obligation at the parent's last-known mailing address.

d. For a review initiated under Iowa Code section 252H.15, if either parent disputes the second decision, the objecting parent may request a court hearing within 15 days from the date the notice of decision is issued or within 10 days of the date the second notice of decision is issued, whichever is later.

e. For a review initiated under Iowa Code section 252H.14A, either parent may request a court hearing within 10 days of the issuance of the second notice of decision.

f. If the unit receives a timely written request or the unit determines that a court hearing is necessary, the unit shall certify the matter to the district court. An objecting parent may seek recourse by filing a private petition for modification through the district court.

[ARC 9352B, IAB 2/9/11, effective 4/1/11; ARC 4576C, IAB 7/31/19, effective 9/4/19]

**441—99.64(252B,252H) Financial information.** The child support recovery unit shall attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be reviewed necessary to conduct the review.

**99.64(1) *Financial statements.*** Except for a review initiated under Iowa Code section 252H.14A, both parents subject to the order to be reviewed shall provide a financial statement and verification of income within ten days of service of the notice of the unit's intent to review the obligation. If a review is initiated under Iowa Code section 252H.14A and the first notice of decision is challenged as described in subrule 99.63(4), both parents shall be requested to provide a financial statement and verification of income within ten days of the unit's request.

a. Verification of income shall include, but not be limited to, the following: copies of state and federal income tax returns, W-2 statements, pay stubs, or a signed statement from an employer or other source of income.

b. The child support recovery unit may also request that the parent requesting review provide an affidavit regarding the financial circumstances of the nonrequesting parent when the unit is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent shall complete the affidavit if the parent possesses sufficient information to do so.

**99.64(2) *Independent sources.*** The child support recovery unit may utilize other resources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be reviewed.

a. These resources include, but are not limited to, the following: the Iowa workforce development department, the Iowa department of revenue, the Internal Revenue Service, the employment, revenue, and child support recovery agencies of other states, and the Social Security Administration.

b. In the absence of other verification of income and deductions allowed under the mandatory support guidelines, the child support recovery unit may estimate the net earned income of a parent for the purpose of determining the amount of support that would be due under the guidelines by deducting 20 percent from the gross earned income confirmed by an independent source. A parent may challenge this estimate by providing verification of actual earned income deductions.

**99.64(3) *Availability of medical insurance.*** Both parents subject to the order to be reviewed shall provide documentation regarding the availability of health insurance coverage for the children covered under the order, and the cost of the coverage, within ten days of a written request by the child support recovery unit. Verification may include, but not be limited to: a copy of the health benefit plan including the effective date of the plan, a letter from the employer detailing the availability of health insurance, or any other source that will serve to verify health insurance information and the cost of the coverage.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

**441—99.65(252B,252H) Review and adjustment of a child support obligation.**

**99.65(1) *Conducting the review.*** The child support recovery unit or its attorney shall review the case for administrative adjustment of a child support obligation unless it is determined that any of the following exist:

a. The location of one or both of the parents is unknown.

b. The variation from the Iowa Supreme Court mandatory child support guidelines is based on any material misrepresentation of fact concerning any financial information submitted to the child support recovery unit.

c. The criteria of rule 441—99.62(252B,252H) are not met.

d. The end date of the order is less than 12 months in the future or the youngest child is 17½ years of age.

**99.65(2) Civil action.** The review and adjustment action that is certified to court for hearing shall proceed as an ordinary civil action in equity, and the child support recovery unit attorney shall represent the state of Iowa in those proceedings.

**99.65(3) Private counsel.** After the notice has been issued as described in subrule 99.63(2) or 99.63(3), any party may choose to be represented personally by private counsel. Any party who retains private counsel shall notify the child support recovery unit of this fact in writing.

[ARC 9352B, IAB 2/9/11, effective 4/1/11; ARC 3719C, IAB 3/28/18, effective 7/1/18]

**441—99.66(252B,252H) Medical support.** The child support recovery unit, or its attorney, shall review the medical support provisions contained in any permanent child support order which is subject to review under rule 441—99.65(252B,252H) and shall include in any adjustment order a provision for medical support as defined in Iowa Code chapter 252E, and as set forth in 441—Chapter 98, Division I, or other appropriate provisions pertaining to medical support for all children affected directly by the child support order under review.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

**441—99.67(252B,252H) Confidentiality of financial information.** Financial information provided to the child support recovery unit by either parent for the purpose of facilitating the review and adjustment process may be disclosed to the other parties to the case, or to the district court, as follows:

**99.67(1) Financial statements.** Statements of financial status may be disclosed to either party.

**99.67(2) Other documentation.** Supporting financial documentation such as state and federal income tax returns, pay stubs, IRS Form W-2, bank statements, and other written evidence of financial status may be disclosed to the court after the notice has been issued as described in subrule 99.63(2) or 99.63(3), unless otherwise prohibited by state or federal law.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

**441—99.68(252B,252H) Payment of service fees and other court costs.** Payment of fees for administrative review or service of process and other court costs associated with the review and adjustment process is the responsibility of the party requesting review unless the court orders otherwise or the requesting party, as a condition of eligibility for receiving public assistance benefits, has assigned the rights to child or medical support for the order to be modified.

A requesting party who is indigent or receiving public assistance may request deferral of fees and costs. For the purposes of the division, “indigent” means that the requesting party’s income is 200 percent or less than the poverty level for one person 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.

**441—99.69(252B,252H) Denying requests.** A request for review by a parent subject to the order may be denied for the following reasons:

**99.69(1)** Rescinded IAB 8/2/95, effective 10/1/95.

**99.69(2)** It has been less than two years since the support order was filed with the court, last modified, or last reviewed for the purpose of adjustment.

**99.69(3)** The child support recovery unit or a child support agency of another state is not providing enforcement services for an ongoing support obligation under the order for which the review has been requested.

**99.69(4)** The request is based entirely on issues such as custody or visitation rights, which are not directly related to child support.

**99.69(5)** The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.

**99.69(6)** The request is for the review of a temporary support order.

**441—99.70(252B,252H) Withdrawing requests.** If the requesting party contacts the child support recovery unit to withdraw the request, the child support recovery unit shall proceed as follows:

**99.70(1) *Best interests of the child.*** Rescinded IAB 2/5/03, effective 4/1/03.

**99.70(2) *Consent of both parties.*** The child support recovery unit shall notify the nonrequesting party of the requesting party's desire to withdraw the request.

*a.* If the nonrequesting party indicates a desire to continue the review, the unit shall proceed with the review and adjust the obligation, if appropriate.

*b.* If the nonrequestor indicates a desire to stop the process or fails to respond within ten days to the notification of the request to withdraw, the unit shall notify all parties that the review and adjustment process has been terminated.

**99.70(3) *Effect of withdrawal.*** If a request is successfully withdrawn pursuant to subrule 99.70(2), a later request by either party shall be subject to the limitations of subrule 99.62(2).

**441—99.71(252H) Effective date of adjustment.** Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation amount shall be effective on the first date that the periodic payment is due under the order being modified after the unit files the adjustment order with the court.

These rules are intended to implement Iowa Code sections 252B.5 to 252B.7 and 598.21C(2) and Iowa Code chapter 252H.

**441—99.72 to 99.80** Reserved.

DIVISION V  
ADMINISTRATIVE MODIFICATION

PREAMBLE

This division implements those provisions of Iowa Code chapter 252H which provide for administrative modification of support obligations when there is a substantial change in the financial circumstances of a party and when both parties agree to a change in an obligation through a cost-of-living alteration. These rules also provide for use of the administrative procedure to modify orders to add children, correct errors, set support which had previously been reserved or set at zero dollars, and increase support for minor obligors who do not comply with statutory educational or parenting class requirements or who are no longer minors.

**441—99.81(252H) Definitions.**

*"Additional child"* means a child to be added to an existing support order covering another child of the same parents.

*"Born of a marriage"* means a child was born of a woman who was married at the time of conception, birth, or at any time during the period between conception and birth of the child pursuant to Iowa Code chapter 252A and Iowa Code section 144.13.

*"Cost-of-living alteration"* means a change in an existing child support order that equals an amount which is the amount of the support obligation following application of the percentage change of the consumer price index for all urban consumers, United States city average, as published in the Federal Register by the federal Department of Labor, Bureau of Labor Statistics, pursuant to Iowa Code section 252H.2.

*"Guidelines"* means the most current guidelines and criteria prescribed by the Iowa Supreme Court for determining the amount of child support to be awarded.

*"Parent"* means a person who is a responsible person or a caretaker, as those terms are defined in rule 441—95.1(252B).

*"Substantial change of circumstances,"* for the purposes of this division, means:

1. There has been a change of 50 percent or more in the net income of a parent, as determined by comparing the new net income with the net income upon which the current child support obligation was based, and

2. The change is due to financial circumstances which have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months, pursuant to Iowa Code section 252H.18A.

**441—99.82(252H) Availability of service.** The child support recovery unit shall provide the services described in this division for a support order originally entered or a foreign order registered in the state of Iowa. The order must be one which:

1. Involves at least one child born of a marriage or one child for whom paternity has been legally established.

2. Is being enforced by the unit in accordance with Iowa Code chapter 252B.

3. Is subject to the jurisdiction of this state for the purposes of modification.

4. Is not subject to or is not appropriate for review and adjustment.

5. Provides for support of at least one child under the age of 18 or a child between the ages of 18 and 19 years who is engaged full-time in completing high school graduation or equivalency requirements in a manner which is reasonably expected to result in completion of the requirements prior to the person's reaching 19 years of age.

6. Has an obligation ending more than 12 months in the future.

7. Involves parents for whom the location of both parents is known.

**441—99.83(252H) Modification of child support obligations.** Permanent child support obligations meeting the criteria set forth in rule 441—99.82(252H) may be modified at the initiative of the unit, or upon written request of either parent subject to the order submitted on Form 470-2749, Request to Modify a Child Support Order. Any action shall be limited to adjustment, modification, or alteration of the child support or medical provisions of the support order. The duration of the underlying order shall not be modified. The procedures used by the child support recovery unit to determine if a modification is appropriate are as follows:

**99.83(1) Substantial change of circumstances.** Procedures to modify the support obligation may be initiated outside the minimum time frame described in subrule 99.62(2) if a request is received from either parent and if the parent has submitted verified documentation of a substantial change in circumstances which indicates both of the following:

a. A change of at least 50 percent in the net income of a parent as defined by guidelines. The new net income will be compared to the net income upon which the current child support obligation was based.

b. The change is due to financial circumstances which have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months.

The unit shall review the request and documentation and, if appropriate, issue a notice of intent to modify as described in subrule 99.84(1).

**99.83(2) Adding provisions for additional children.** Procedures to modify the support obligation may be initiated if:

a. A parent requests, in writing, or the unit determines that it is appropriate to add an additional child to the support order and modify the obligation amount according to the guidelines pursuant to Iowa Code section 598.21B and Iowa Code section 252B.7A; and

b. Paternity has been legally established.

When adding a child to an order through administrative modification, medical support provisions shall apply to the additional child.

**99.83(3) Reserved, zero-dollar-amount, or medical-provisions-only orders.** Procedures to modify the support obligation may be initiated if:

a. A parent requests a modification in writing or the unit determines that it is appropriate to include a support amount based on the guidelines; and

*b.* The original order:

- (1) Reserved establishment of an ongoing, dollar-amount support obligation giving a specific reason other than lack of personal jurisdiction over the obligor, or
- (2) Set the amount at zero, or
- (3) Was for medical provisions only.

**99.83(4) *Corrections.*** Procedures to modify the support obligation may be initiated if:

- a.* An error or omission pertaining to child support or medical provisions was made during preparation or filing of a support order; and
- b.* A necessary party requests a modification or the unit determines that a modification to correct an error or omission is appropriate.

**99.83(5) *Noncompliance by minor obligors.*** The unit may initiate procedures to modify a support order if a parent requests modification in writing or the unit determines that it is appropriate when:

- a.* An obligor who is under 18 years of age fails to comply with the requirement to attend parenting classes pursuant to Iowa Code section 598.21G; or
- b.* An obligor who is 19 years of age or younger fails to provide proof of compliance with education requirements described in Iowa Code section 598.21B(2) “*e*”; or
- c.* The obligor no longer meets the age requirements as defined in Iowa Code section 598.21B(2) “*e*” or 598.21G.

**99.83(6) *Cost-of-living alteration.*** A support order may be modified to provide a cost-of-living alteration if all the following criteria are met:

- a.* A parent requests a cost-of-living alteration in writing.
- b.* At least two years have passed since the order was filed with the court or last reviewed, modified, or altered.
- c.* The nonrequesting parent signs a statement agreeing to the cost-of-living alteration of the support order.
- d.* Each parent signs a waiver of personal service accepting service by regular mail.
- e.* The current support order addresses medical support for the children.
- f.* A copy of each affected order is provided, if the unit does not already have copies in its files.

[ARC 9352B, IAB 2/9/11, effective 4/1/11; ARC 1357C, IAB 3/5/14, effective 5/1/14]

**441—99.84(252H) Notice requirements.** The child support recovery unit shall provide written notification to parents affected by a permanent child support obligation being enforced by the unit as follows:

**99.84(1) *Notice of intent to modify.*** When a request for administrative modification is received or the unit initiates an administrative modification, the unit shall provide written notice to each parent of its intent to modify.

*a.* The notice shall include the legal basis and purpose for the action; a request for income or other information necessary for the application of guidelines (if applicable); an explanation of the legal rights and responsibilities of the affected parties, including time frames; and procedures for contesting the action.

*b.* The unit shall take the following actions to notify parents:

- (1) Rescinded IAB 2/5/03, effective 4/1/03.
- (2) If the modification is based on subrules 99.83(1) through 99.83(5), notice shall be provided to each parent. The notice shall be served in accordance with the Iowa Rules of Civil Procedure or Iowa Code section 252B.26 or 252H.19.

(3) If the modification is based on provision of a cost-of-living alteration as established at subrule 99.83(6) and the required documentation is included, the child support recovery unit shall notify each parent of the amount of the cost-of-living alteration by regular mail to the last-known address of each parent or, if applicable, each parent’s attorney. The notice shall include:

1. The method of determining the amount of the alteration pursuant to Iowa Code section 252H.21.
2. The procedure for contesting a cost-of-living alteration by making a request for review of a support order as provided in Iowa Code section 252H.24.

3. A statement that either parent may waive the 30-day notice waiting period. If both parents waive the notice waiting period, the unit may prepare an administrative order altering the support obligation.

**99.84(2) Notice of decision to modify.** The unit shall issue a notice of its decision to modify the support order to each parent affected by the support obligation at each parent's (or attorney's) last-known address. The notice shall contain information about whether the unit will continue or terminate the action and the procedures and time frames for contesting the action by requesting a court hearing pursuant to 441—subrule 99.86(2).

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

**441—99.85(252H) Financial information.** The child support recovery unit may attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be modified that is necessary to conduct an analysis and determine support. The unit does not require financial information if the request is for a cost-of-living alteration.

**99.85(1) Financial statements.** Parents subject to the order shall provide a financial statement and verification of income within ten days of a written request by the unit.

a. If the modification action is based on a substantial change of circumstances:

(1) The requesting party must provide Form 470-2749, Request to Modify a Child Support Order, and documentation that proves the amount of change in net income and the date the change took place, such as:

1. Copies of state and federal income tax returns, W-2 statements, or pay stubs, or
2. A signed statement from an employer or other source of income.

(2) The unit shall review the request and documentation. If appropriate, the unit shall issue to each parent a notice of intent to modify the order as stated in subrule 99.84(1) and a financial statement. Each parent shall complete and sign the financial statement and return it to the unit with verification of income and deductions as described in subrule 99.1(3).

b. The unit may require a completed and signed financial statement and verification of income from each parent as described in subrule 99.1(3) if the modification is based on:

- (1) Addition of a child;
- (2) Changing a reserved or zero-dollar-amount obligation;
- (3) Changing a medical-provisions-only obligation;
- (4) Making a correction (if financial information is needed); or
- (5) Noncompliance by a minor obligor as defined in Iowa Code section 598.21B(2) "e" or 598.21G.

c. The unit may also request that a parent requesting a modification provide an affidavit regarding the financial circumstances of the nonrequesting parent when the unit is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent shall complete the affidavit if the parent possesses sufficient information to do so.

d. The unit may also use the most recent wage rate information published by the department of workforce development or the median income for parents on the unit caseload to estimate the net earned income of a parent when a parent has failed to return a completed financial statement when requested and complete and accurate information is not readily available from other sources.

e. Self-employment income will be determined as described in subrule 99.1(5).

**99.85(2) Independent sources.** The child support recovery unit may use other resources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be modified as described in rule 441—99.1(234,252B).

**99.85(3) Guidelines calculations.**

a. The unit shall determine:

(1) The appropriate amount of the child support obligation (excluding cost-of-living alteration amounts) as described in rules 441—99.1(234,252B) through 441—99.5(234,252B), and

(2) Medical support provisions as described in Iowa Code chapter 252E and rules 441—98.1(252E) through 441—98.7(252E).

b. If the modification action is due to noncompliance by a minor obligor, as defined in Iowa Code section 598.21B(2) "e" or 598.21G, the unit will impute an income to the obligor equal to a 40-hour

workweek at the state minimum wage unless the parent's education, experience, or actual earnings justify a higher income.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

**441—99.86(252H) Challenges to the proposed modification action.** For modification actions based on subrules 99.83(1) through 99.83(5), each parent shall have the right to request a conference to contest the proposed modification. Either parent, or the unit, may also request a court hearing. For requests made based on subrule 99.83(6), either parent may contest the cost-of-living alteration by making a request for a review and adjustment of the support order.

**99.86(1) Conference.** Either parent may contest the proposed modification based on subrules 99.83(1) through 99.83(5) by means of a conference with the office of the unit that issued the notice of intent to modify.

- a. Only one conference shall be held per parent.
- b. The request must be made within ten days of the date of service of the notice of intent to modify.
- c. The office that issued the notice of intent to modify shall schedule a conference with the parent and advise the parent of the date, time, place, and procedural aspects of the conference.
- d. Reasons for contesting the modification include, but are not limited to, mistake of fact regarding the identity of one of the parties or the amount or terms of the modification.
- e. The child support recovery unit may conduct the conference in person or by telephone.
- f. If the party who requested the conference fails to attend the conference, only one alternative time shall be scheduled by the child support recovery unit.
- g. The results of a conference shall in no way affect the right of either party to request a court hearing pursuant to subrule 99.86(2).
- h. Upon completion of the conference, the unit shall issue a notice of decision to modify as described in subrule 99.84(2).

**99.86(2) Court hearing.**

- a. Either parent, or the unit, may contest the proposed modification, based on subrules 99.83(1) through 99.83(5), by requesting a court hearing within the latest of any of the following time periods:
  - (1) Twenty days from the date of successful service of the notice of intent to modify,
  - (2) Ten days from the date scheduled for a conference, or
  - (3) Ten days from the date of issuance of a notice of decision to modify.
- b. If the unit receives a timely written request, the unit shall certify the matter to the district court as described in Iowa Code section 252H.8.
- c. If a timely request is not received, if waiting periods have been waived, or if the notice periods have expired, the unit shall prepare an administrative order as provided in Iowa Code section 252H.9.

**99.86(3) Contesting a proposed cost-of-living alteration.** Either parent may contest a cost-of-living alteration within 30 days of the date of the notice of intent to modify by making a request for a review of the support order as provided in Iowa Code section 252H.13.

- a. If the unit receives a timely written request for review, the unit shall terminate the cost-of-living alteration process and proceed with the review and adjustment process.
- b. If a timely request is not made, or the notice waiting period has been waived by both parties, or the notice period has expired, the unit shall prepare an administrative order as provided in Iowa Code section 252H.24.

**441—99.87(252H) Misrepresentation of fact.**

**99.87(1)** The unit shall not modify the support order based on a substantial change of circumstances if a change in income is due to any material misrepresentation of fact concerning any financial information submitted to the child support recovery unit.

**99.87(2)** The unit may request verification that all facts concerning financial information are true. Verification may include, but is not limited to, a statement from the employer, a doctor, or other person with knowledge of the situation.

[ARC 3719C, IAB 3/28/18, effective 7/1/18]

**441—99.88(252H) Effective date of modification.** Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation shall be effective on the first date that the periodic payment is due under the order being modified after the unit files the modification order with the court. If the modification is based on a reserved, zero-dollar-amount, or medical-provisions-only obligation, the new obligation shall be effective 20 days after generation of the administrative modification order.

**441—99.89(252H) Confidentiality of financial information.** Financial information provided to the child support recovery unit by either parent for the purpose of facilitating the modification process may be disclosed to the other parties to the case, or the district court, as follows:

**99.89(1) *Financial statements.*** The financial statement or affidavit may be disclosed to either party.

**99.89(2) *Other documentation.*** Supporting financial documentation such as state and federal income tax returns, paycheck stubs, IRS Form W-2, bank statements, and other written evidence of financial status may be disclosed to the court unless otherwise prohibited by state or federal law.

**441—99.90(252H) Payment of fees.** Payment of service of process and other costs associated with the modification process is the responsibility of the party requesting modification unless the court orders otherwise or the requesting party, as a condition of eligibility for receiving public assistance benefits, has assigned the rights to child or medical support for the order to be modified.

A requesting party who is indigent or receiving public assistance may request deferral of fees and costs. For the purposes of this division, “indigent” means that the requesting party’s income is 200 percent or less than the poverty level for one person as defined by the United State Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

**441—99.91(252H) Denying requests.** A request for modification by a parent subject to the order may be denied if the criteria in rule 441—99.82(252H) are not met or the following conditions exist:

**99.91(1) *Nonsupport issues.*** The request is based entirely on issues such as custody or visitation rights.

**99.91(2) *Request only for delinquent support.*** The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.

**99.91(3) *Temporary order.*** The request is for the modification of a temporary support order.

**99.91(4) *Two-year time frame.*** The request is for a cost-of-living alteration and it has been less than two years since the order was filed with the court or last reviewed, modified, or altered.

**99.91(5) *Change of circumstances.*** The request is based on a substantial change in circumstances and:

*a.* The requestor’s net income has not changed by at least 50 percent, as required in paragraph 99.83(1) “*a,*” or

*b.* The requestor has not provided adequate documentation of the change in income, as required in subrule 99.85(1), or

*c.* The change in income has not yet lasted for three months, as required in paragraph 99.83(1) “*b,*” or

*d.* The change in income is not expected to last another three months, as required in paragraph 99.83(1) “*b,*” or

*e.* The change in income is due to material misrepresentation of fact, as explained in rule 441—99.87(252H).

[ARC 3719C, IAB 3/28/18, effective 7/1/18]

**441—99.92(252H) Withdrawing requests.** If the requesting party contacts the child support recovery unit to withdraw the request, the child support recovery unit shall notify the nonrequesting party of the requesting party’s desire to withdraw the modification request. If the nonrequesting party indicates, in writing, a desire to continue with the modification process, the child support recovery unit shall proceed, and if appropriate, modify the support order. If there is no response from the nonrequesting party or if the nonrequesting party also wants the process to end, the unit shall end the modification process. If the

unit initiated the modification action, the unit may terminate the process if, after notifying both parents, neither parent indicates a desire to continue with the modification.

These rules are intended to implement Iowa Code chapter 252H.

**441—99.93 to 99.100** Reserved.

DIVISION VI  
SUSPENSION AND REINSTATEMENT OF SUPPORT  
PART A  
SUSPENSION BY MUTUAL CONSENT

**441—99.101(252B) Definitions.** As used in this part, unless the context otherwise requires:

“*Caretaker*” means a natural person with whom a child is residing and who is not legally entitled to receive support for that child pursuant to the order that is the subject of the pending suspension request.

“*Child*” means the same as defined in Iowa Code section 252E.1.

“*Child support recovery unit*” or “*unit*” means the same as defined in rule 441—95.1(252B) and Iowa Code section 252B.1.

“*Obligee*” means a custodial parent or other natural person legally entitled to receive a support payment on behalf of a child.

“*Obligor*” means a noncustodial parent or other natural person who is ordered to pay support pursuant to the order that is the subject of the pending suspension request.

“*Public assistance*” means the same as defined in Iowa Code section 252H.2.

“*Spousal support*” means either a set amount of monetary support, or medical support as defined in Iowa Code section 252E.1, for the benefit of a spouse or former spouse, including alimony, maintenance, or any other term used to describe these obligations.

“*Step change*” means a change designated in a support order that specifies the amount of the child support obligation as the number of children entitled to support under the order changes.

“*Support*” means the same as defined in Iowa Code section 252D.16, and shall include spousal support and support for a child.

“*Support for a child*” means either a set amount of monetary support (child support), or medical support as defined in Iowa Code section 252E.1, for the benefit of a child. This term does not include spousal support as defined in this rule.

“*Support order*” means the same as a “court order” as defined in Iowa Code section 252C.1.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.102(252B) Availability of service.** The child support recovery unit shall provide the services described in this part only with respect to support orders entered or registered in this state for which the unit is providing enforcement services in accordance with Iowa Code chapter 252B to collect current or accrued support.

**99.102(1)** Services described in this part shall only be provided if a court in this state would have continuing, exclusive jurisdiction to suspend and reinstate the order under Iowa Code chapter 252K.

**99.102(2)** Services described in this part shall be provided only if no prior request for suspension of all or part of a support order has been filed with the unit pursuant to Iowa Code section 252B.20 and no prior request for suspension of all or part of a support order has been served by the unit pursuant to Iowa Code section 252B.20A during the two-year period preceding the request.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.103(252B) Basis for suspension of support.**

**99.103(1) Reconciliation.** The child support recovery unit shall assist an obligor and obligee in suspending support for a child and, if contained in a child support order, spousal support, when the obligor and obligee are reconciled and are residing together, with at least one child entitled to support under the order, in the same household.

**99.103(2) Change in residency.** The unit shall assist an obligor and obligee in suspending support for a child when the child is residing with the obligor; however, the unit shall not assist in suspending

any spousal support provisions of a support order on this basis. The unit shall also assist an obligor and obligee in suspending support for a child residing with a caretaker who has not requested unit services, if the child is not receiving public assistance.

**99.103(3) *Affected children.*** The unit shall assist an obligor and obligee in suspending all or part of a support order as provided in this part if the basis for suspension as described in this rule applies to the children entitled to support under the order to be suspended as follows:

*a.* If the basis for suspension applies to all of the children, the unit shall assist in suspending support obligations for all of the children.

*b.* If the basis for suspension applies to at least one but not all of the children and if the support order includes a step change, the unit shall assist in suspending the support obligations for children for whom the basis for suspension applies.

**99.103(4) *Limited to current support.*** The provisions in this part for suspending support apply only toward ongoing or current support. Any support that has accrued prior to the entry of an order suspending support, including judgments for past periods of time, is unaffected by the suspension.

**99.103(5) *Duration of conditions.*** The basis for suspension of support as provided in subrule 99.103(2) and subrule 99.103(3) must reasonably be expected to continue for not less than six months from the date a request for assistance to suspend is received by the child support recovery unit.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

#### **441—99.104(252B) Request for assistance to suspend.**

**99.104(1) *Submitting a request.*** The obligor and obligee subject to a support order being enforced by the unit may request that the unit assist in having the ongoing support provisions suspended as follows:

*a.* A request for suspension shall be submitted to the local child support unit providing services using Form 470-3033, Request to Suspend Support, and Form 470-3032, Affidavit Regarding Suspension of Support.

*b.* The unit shall provide Forms 470-3032 and 470-3033 to the obligor or obligee upon request.

*c.* Both forms must be signed by both the obligor and the obligee affected by the order to be suspended. In the event that current support payments are assigned to an individual or entity other than the obligee named in the original order, but may revert to the original obligee at a future date without court action, both the original obligee and the current assignee must sign both forms.

*d.* Form 470-3032 must be notarized.

*e.* The request shall contain sufficient information to allow the local unit to identify the court order and parties involved, and a statement that the obligor and obligee expect the basis for suspension to continue for not less than six months.

*f.* If the obligor and obligee are requesting suspension of more than one order at the same time, the obligor and obligee shall be required to submit only one copy of Form 470-3033, identifying each order the request involves; however, the obligor and obligee shall be required to submit a separate, signed and notarized affidavit, Form 470-3032, for each order.

**99.104(2) *Denying a request.*** The local unit providing services shall issue a written notice to the obligor and obligee indicating that a properly completed request is denied.

*a.* This notice shall be sent by first-class regular mail to the last-known address of the obligor and obligee or, if applicable, to the last-known address of the obligor's or obligee's attorney.

*b.* If the basis for suspension is reconciliation, one notice shall be sent to the address shared by the obligor and obligee. If the basis for suspension is a change in residency of the children entitled to support, a separate notice shall be issued to the obligor and obligee at their respective last-known addresses.

*c.* The notice denying a request shall indicate the reason for denial.

*d.* A request for suspension shall be denied when the conditions specified in Iowa Code section 252B.20, rule 441—99.102(252B), or rule 441—99.103(252B) are not met.

*e.* Denial of a request is not subject to appeal or review under Iowa Code chapter 17A.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.105(252B) Order suspending support.** To approve a request to suspend support, the unit shall prepare and present to the district court an order suspending support as provided in Iowa Code section 252B.20.

**99.105(1)** When the basis for suspension is reconciliation, the suspension shall apply to any ongoing support provisions of the order, including medical support, with respect to any child residing with the parents and with respect to any spouse or former spouse entitled to support under the order to be suspended.

**99.105(2)** When the basis for suspension is a change in residency of one or more of the children entitled to support, the suspension shall apply to ongoing support provisions, including medical support, with respect to only the children entitled to support under the order who are residing with the obligor. Any spousal support also ordered in the same support order shall remain unaffected by this action.

**99.105(3)** A copy of the filed order shall be sent by first-class regular mail to the last known address of the obligor and obligee, or, if applicable, to the last known address of the obligor's or obligee's attorney.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.106(252B) Suspension of enforcement of current support.** The child support recovery unit shall suspend enforcement actions intended to collect or enforce any current support obligation that would have accrued during the time the support obligation is suspended. The unit shall continue to provide all appropriate enforcement services to collect any support not suspended and any arrearages that accrued before the effective date of the suspension.

PART B  
SUSPENSION BY PAYOR'S REQUEST

**441—99.107(252B) Definitions.** As used in this part, unless the context otherwise requires:

*“Caretaker”* means a natural person with whom a child is residing and who is not legally entitled to receive support for that child pursuant to the order that is the subject of the pending suspension request.

*“Child”* means the same as defined in Iowa Code section 252E.1.

*“Child support recovery unit”* or *“unit”* means the same as defined in rule 441—95.1(252B) and Iowa Code section 252B.1.

*“Obligee”* means a custodial parent or other natural person legally entitled to receive a support payment on behalf of a child.

*“Obligor”* means a noncustodial parent or other natural person who is ordered to pay support pursuant to the order that is the subject of the pending suspension request.

*“Public assistance”* means the same as defined in Iowa Code section 252H.2.

*“Step change”* means a change designated in a support order that specifies the amount of the child support obligation as the number of children entitled to support under the order changes.

*“Support”* means the same as defined in Iowa Code section 252D.16 and shall include support for a child.

*“Support for a child”* means either a set amount of monetary support (child support), or medical support as defined in Iowa Code section 252E.1, for the benefit of a child. This term does not include spousal support as defined in rule 441—99.101(252B).

*“Support order”* means the same as a “court order” as defined in Iowa Code section 252C.1.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.108(252B) Availability of service.** The child support recovery unit shall provide the services described in this part only with respect to support orders entered pursuant to Iowa Code chapter 252A, 252C or 252F for which the unit is providing enforcement services in accordance with Iowa Code chapter 252B to collect current or accrued support.

**99.108(1)** Services described in this part shall only be provided if a court in this state would have continuing, exclusive jurisdiction to suspend and reinstate the order pursuant to Iowa Code chapter 252K.

**99.108(2)** Services described in this part shall be provided only if no prior request for suspension of all or part of a support order has been filed with the unit pursuant to Iowa Code section 252B.20 and no prior request for suspension of all or part of a support order has been served by the unit pursuant to Iowa Code section 252B.20A during the two-year period preceding the request.  
[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.109(252B) Basis for suspension of support.**

**99.109(1)** *Child residing with obligor or caretaker.* The unit shall assist an obligor in suspending support for a child residing with the obligor or with a caretaker who has not requested unit services, if the child has been residing with the obligor or caretaker for more than 60 consecutive days.

**99.109(2)** *Orders eligible for suspension.*

*a.* The unit shall assist an obligor in suspending support for a child under this part only when there is no order in effect regarding legal custody, physical care, visitation or other parenting time for the child.

*b.* If an order exists that contains language regarding legal custody, physical care, visitation or other parenting time for the child, the unit shall deny the suspension request.

**99.109(3)** *Children on public assistance.* The children for whom ongoing support is being suspended shall not be receiving public assistance pursuant to Iowa Code chapter 239B or 249A or a comparable law of another state or foreign country, or if the children are receiving public assistance, the obligor must be considered to be a member of the same household as the children for the purposes of public assistance eligibility.

**99.109(4)** *Duration of conditions.* The basis for suspension of support under this part must reasonably be expected to continue for not less than six months from the date a request for assistance to suspend is received by the child support recovery unit.

**99.109(5)** *Affected children.* The unit shall assist an obligor in suspending all or part of a support order as provided in this part if the basis for suspension as described in this rule applies to the children entitled to support under the order to be suspended as follows:

*a.* If the basis for suspension applies to all of the children, the unit shall assist in suspending support obligations for all of the children.

*b.* If the basis for suspension applies to at least one but not all of the children and if the support order includes a step change, the unit shall assist in suspending the support obligations for children for whom the basis for suspension applies.

**99.109(6)** *Limited to current support.* The provisions in this part for suspending support apply only toward ongoing or current support. Any support that has accrued prior to the entry of an order suspending support, including judgments for past periods of time, is unaffected by the suspension.  
[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.110(252B) Request for assistance to suspend.** The obligor subject to a support order being enforced by the unit may request that the unit assist in having the ongoing support provisions suspended as follows:

**99.110(1)** *Submitting a request.*

*a.* A request for suspension shall be submitted to the local child support unit providing services using Form 470-5348, Request from the Payor to Suspend Support.

*b.* The unit shall provide Form 470-5348 to the obligor upon request.

*c.* The request form must be signed by the obligor affected by the order to be suspended.

*d.* The request shall contain sufficient information to allow the local unit to identify the court order and parties involved and shall attest that the children have lived in the obligor's household or the caretaker's household for more than 60 consecutive days and are expected to live there for at least six months.

**99.110(2)** *Submitting an affidavit.* After receiving a valid request for suspension, the local unit shall provide the requestor with Form 470-5349, Affidavit Requesting Suspension of Support Based on Payor's Request.

a. The obligor shall submit the affidavit for suspension to the local child support unit providing services. If the request for suspension is made pursuant to Iowa Code section 252B.20A(17), the caretaker must also submit an affidavit, Form 470-5349.

b. Form 470-5349 must be signed, attesting to the existence of the conditions under subrules 99.109(1) through 99.109(4). Form 470-5349 must be notarized.

c. If the obligor is requesting suspension of more than one order at the same time, the obligor shall be required to submit only one copy of Form 470-5348, identifying each order the request involves; however, the obligor shall be required to submit a separate, signed and notarized affidavit, Form 470-5349, for each order.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.111(252B) Determining eligibility for suspension.** Upon receipt of the request for suspension and the properly executed and notarized affidavit, the unit shall review the request and the affidavit to determine that the criteria have been met.

**99.111(1) *If the criteria are not met.*** If the criteria have not been met, the local unit providing services shall issue a written notice to the obligor indicating that the request is denied.

a. The notice shall be sent by first-class regular mail to the last-known address of the obligor or, if applicable, to the last-known address of the obligor's attorney.

b. The notice shall indicate the reason for denial and notify the obligor of the right to proceed through private counsel. Denial of the request is not subject to contested case proceedings or further review pursuant to Iowa Code chapter 17A.

**99.111(2) *If the criteria are met.*** If the criteria are met, the unit shall proceed as follows:

a. The unit shall serve Form 470-5351, Notice of Intent to Payee to Suspend a Child Support Obligation Based on Payor's Request, and Form 470-5352, Payee's Affidavit Objecting to Suspension of Support, and supporting documents on the obligee by any means provided in Iowa Code section 252B.26. The notice to the obligee shall include all of the following:

(1) Information sufficient to identify the parties and the support order affected.

(2) An explanation of the procedure for suspension under Part B and reinstatement of support under Part C of this division.

(3) An explanation of the rights and responsibilities of the obligee to respond to the action.

(4) A statement that, within 20 days of service, the obligee must submit a signed and notarized response to the unit objecting to at least one of the assertions in subrules 99.109(1) through 99.109(4). The statement shall inform the obligee that if, within 20 days of service, the obligee fails to submit a response as specified in this subparagraph, notwithstanding Rules of Civil Procedure 1.972(2) and 1.972(3), the unit will prepare and submit an order.

b. No sooner than 30 days after service on the obligee, the unit shall do one of the following:

(1) If the obligee submits a signed and notarized objection to at least one of the assertions in subrules 99.109(1) through 99.109(4), deny the request and notify the parties in writing that the request is denied, providing reasons for the denial, and notifying the parties of the right to proceed through private counsel. Denial of the request is not subject to contested case proceedings or further review pursuant to Iowa Code chapter 17A.

(2) If the obligee cannot be served, the local unit providing services shall issue a written notice to the obligor indicating the request is denied, following the procedure described in subrule 99.111(2).

(3) If the obligee does not timely submit a signed and notarized objection to the unit, prepare an order following the procedure described in rule 441—99.112(252B).

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.112(252B) Order suspending support.** After approving a request to suspend support and properly serving the obligee, the unit shall prepare and present to the district court an order suspending support as provided in Iowa Code section 252B.20A.

**99.112(1)** The suspension shall apply to ongoing support provisions, including medical support, with respect to only the children entitled to support under the order who are residing with the obligor or caretaker.

**99.112(2)** A copy of the filed order shall be sent by first-class regular mail to the last-known address of the obligor and obligee or, if applicable, to the last-known address of the obligor's or obligee's attorney. [ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.113(252B) Suspension of enforcement of current support.** The child support recovery unit shall suspend enforcement actions intended to collect or enforce any current support obligation that would have accrued during the time the support obligation is suspended. The unit shall continue to provide all appropriate enforcement services to collect any support not suspended and any arrearages that accrued before the effective date of the suspension. [ARC 2813C, IAB 11/9/16, effective 1/1/17]

PART C  
REINSTATEMENT OF SUPPORT

**441—99.114(252B) Request for reinstatement.** The unit may request that the court reinstate the suspended support obligation in accordance with the procedures found in Iowa Code sections 252B.20 and 252B.20A.

**99.114(1)** Either the obligor or the obligee affected by the suspended order may request reinstatement by submitting a written request for reinstatement to the child support recovery unit. The request must indicate that reinstatement is being requested and the reason for reinstatement and must contain sufficient information to identify the court order and parties involved. The request must also be signed by the requesting party.

**99.114(2)** The unit may, at its own initiative, request that the court reinstate a support obligation when it is determined that a child for whom the obligation was suspended is receiving public assistance benefits.

**99.114(3)** The unit shall issue a written notice approving or denying the request to any obligor or obligee requesting reinstatement. This notice shall be sent by first-class regular mail to the last-known address of the requesting party and shall indicate any reason for denial.

**99.114(4)** A properly completed request for reinstatement shall be denied when any of the following conditions exist:

- a.* The request is made by someone other than the obligor, the obligee, or the obligor's or obligee's attorney.
- b.* The unit is no longer providing enforcement services for the suspended order.
- c.* The request is received more than six months after the date of the filing of the order suspending support.
- d.* The request is for partial reinstatement of the suspended support order for some but not all of the children, and the order does not contain a step change.
- e.* A court in this state would not have continuing, exclusive jurisdiction to reinstate the order under Iowa Code chapter 252K.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.115(252B) Reinstatement.** The child support recovery unit shall follow the procedures in Iowa Code sections 252B.20 and 252B.20A in seeking to have the court reinstate a support order.

**99.115(1)** The unit shall request that the court reinstate a spousal support provision previously suspended if the provision was included in the suspension in accordance with subrule 99.105(1) and if the unit receives a properly completed request from the obligor or the obligee.

**99.115(2)** The unit shall seek to have the previously suspended support for a child reinstated under this part when the conditions in paragraph "a" or "b" of this subrule are met. This provision shall not prohibit any party, including the child support recovery unit, from taking other action to establish support as provided for by law.

- a.* The basis for suspension no longer applies to any of the children for whom support was suspended; or

*b.* The basis for suspension continues to apply to some but not all of the children for whom support was suspended, and there is a step change in the order.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.116(252B) Reinstatement of enforcement of support.** If a suspended support obligation is reinstated, the unit shall also reinstate all appropriate enforcement measures to enforce all reinstated ongoing support provisions of the support order.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

**441—99.117(252B) Temporary suspension becomes final.** The temporary suspension of a support order under this division shall become final if not reinstated in accordance with Iowa Code sections 252B.20 and 252B.20A.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

The rules in this division are intended to implement Iowa Code sections 252B.20 and 252B.20A.

**441—99.118 to 99.120** Reserved

DIVISION VII  
APPEALS

**441—99.121(17A) Right of appeal.** Department actions under this chapter are not subject to administrative appeal under 441—Chapter 7.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 5417C, IAB 2/10/21, effective 4/1/21]

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[Filed ARC 2813C (Notice ARC 2702C, IAB 8/31/16), IAB 11/9/16, effective 1/1/17]

[Filed ARC 3719C (Notice ARC 3595C, IAB 1/31/18), IAB 3/28/18, effective 7/1/18]

[Filed ARC 4576C (Notice ARC 4441C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]

[Filed ARC 5417C (Notice ARC 5274C, IAB 11/18/20), IAB 2/10/21, effective 4/1/21]



CHAPTER 100  
CHILD SUPPORT PROMOTING OPPORTUNITIES FOR PARENTS PROGRAM

PREAMBLE

This chapter describes the promoting opportunities for parents program developed by the department of human services child support recovery unit (CSRU). The purpose of this program is to assist parents in overcoming the barriers which interfere with fulfilling their obligations to their children. For the purpose of these rules, promoting opportunities includes emotional and personal involvement of the parents, parenting or fatherhood classes and employment resources beyond simply meeting the parents' financial obligations. In order to encourage participation by parents, CSRU may partner with community providers and resources and may offer various incentives for participation. These incentives may be offered through projects whose plans have been approved by the bureau chief or through projects in which CSRU participates and for which the bureau chief approves of CSRU's offering any or all of the incentives.

[ARC 3720C, IAB 3/28/18, effective 7/1/18]

**441—100.1(252B) Definitions.**

*“Assigned support arrearages”* means support arrearages for which all rights have been and shall remain assigned to the state of Iowa.

*“Bureau chief”* means the chief of the bureau of collections of the department of human services or the bureau chief's designee.

*“Child support recovery unit (CSRU)”* means any person, unit, or other agency which is charged with responsibility for providing or assisting in the provision of child support enforcement services pursuant to Title IV-D of the Social Security Act.

*“Designated provider”* means any project approved in whole or in part by CSRU and approved by the bureau chief to assist parents in overcoming the barriers which interfere with their fulfilling obligations to their children. Each project shall have a project plan approved by the bureau chief.

*“Incentives”* means, but is not limited to, satisfaction of support obligations and bypass of select enforcement tools such as license sanction, administrative levy, and contempt.

*“Participant”* means a person who receives services or incentives through a project.

*“Periodic support payment”* means the total support payment due in each time period in accordance with the established support obligation. If no current support is due, the periodic support payment is equivalent to the last current support amount as would be ordered under 441—Chapter 98, Division II.

*“Project plan”* means the written policies, procedures, eligibility criteria and other components, as described at subrule 100.3(2).

[ARC 3720C, IAB 3/28/18, effective 7/1/18]

**441—100.2(252B) Incentives.** CSRU may offer incentives to participants through designated providers to encourage participants' completion of the project. The available incentives include, but are not limited to, the following:

**100.2(1) Satisfaction of the assigned support arrearages.**

*a.* A participant shall be granted a partial satisfaction of the assigned support arrearages which are and which will remain owed by that participant to the state after that participant's successful completion of the project and payment of that participant's periodic support payments. Satisfactions granted under this subrule shall apply only to those cases for which periodic support payment is credited.

*b.* Each satisfaction shall be an amount equal to a percentage of that participant's support arrearages, which are and which will remain owed to the state, according to the following schedule:

(1) A one-time satisfaction after 6 consecutive months from the participant's completion of the project. The amount of satisfaction shall be a percentage based on the amount of periodic support paid on all qualifying cases as follows:

1. When 100 percent of the periodic support is paid, the satisfaction amount will equal 50 percent of the amount owed to the state.

2. When 99 to 80 percent of the periodic support is paid, the satisfaction amount will equal 40 percent of the amount owed to the state.

3. When 79 to 60 percent of the periodic support is paid, the satisfaction amount will equal 30 percent of the amount owed to the state.

4. When 59 to 40 percent of the periodic support is paid, the satisfaction amount will equal 20 percent of the amount owed to the state.

5. When 39 to 20 percent of the periodic support is paid, the satisfaction amount will equal 10 percent of the amount owed to the state.

6. When 19 to 0 percent of the periodic support is paid, the satisfaction amount will equal 0 percent of the amount owed to the state.

(2) A one-time satisfaction after 12 consecutive months from the participant's completion of the project. The amount of satisfaction shall be a percentage based on the amount of periodic support paid on all qualifying cases as follows:

1. When 100 percent of the periodic support is paid, the satisfaction amount will equal 100 percent of the amount owed to the state.

2. When 99 to 80 percent of the periodic support is paid, the satisfaction amount will equal 80 percent of the amount owed to the state.

3. When 79 to 60 percent of the periodic support is paid, the satisfaction amount will equal 60 percent of the amount owed to the state.

4. When 59 to 40 percent of the periodic support is paid, the satisfaction amount will equal 40 percent of the amount owed to the state.

5. When 39 to 20 percent of the periodic support is paid, the satisfaction amount will equal 20 percent of the amount owed to the state.

6. When 19 to 0 percent of the periodic support is paid, the satisfaction amount will equal 0 percent of the amount owed to the state.

c. A participant subject to an income withholding order shall be eligible for the satisfaction in this subrule if the sole reason for ineligibility is a disparity between the schedules of the participant's pay date and the scheduled date the payment is due.

d. A participant shall be eligible for a satisfaction under this subrule if the participant is no longer a participant but has continued to pay the participant's periodic support payment without interruption.

**100.2(2) Enforcement processes.** CSRU may bypass select enforcement tools, including but not limited to license sanction, administrative levy, and contempt, if the participant is actively in the project. [ARC 3720C, IAB 3/28/18, effective 7/1/18]

**441—100.3(252B) Establishment of designated providers.** CSRU may initiate a request for project plans to become designated providers.

**100.3(1) Contents of a request for project plans.** The request for project plans shall contain the requirements for contents of the project plan and any other parameter for the specific project being advertised. The request shall also contain a deadline by which project plans must be submitted to the bureau chief.

**100.3(2) Contents of project plans.** Each project shall have and maintain a project plan. At a minimum, the project plan shall contain or address the following:

a. The applicant's experience and success at integrating collaborations and services essential to the project.

b. The geographic area to be served and community need for projected services.

c. The projected number of participants to be served and the criteria to be used for the selection and termination of participants.

d. The specific parenting curriculum to be used. The curriculum must be well-established, have a track record of use and be field-tested.

e. A description of the components of the curriculum. The components of the curriculum should include personal development, responsible parenting, parenting skills, financial responsibilities, communication skills, and domestic violence prevention.

- f.* The schedule, location, hours of instruction and format for administering the curriculum.
- g.* A description of the organization and identification of staff responsible for delivering the curriculum. The staff should have experience in group facilitation and be certified trainers in the curriculum.
- h.* A clear explanation of how the curriculum and services will be monitored and evaluated, including how the participants will be tracked and what data will be collected.
- i.* Project duration.

**100.3(3) Amendments to project plan.** Projects may submit proposed amendments to their project plan in writing to the bureau chief. The bureau chief shall have the option, after review, of approving or disapproving all proposed amendments to the project plan.

[ARC 3720C, IAB 3/28/18, effective 7/1/18]

**441—100.4(252B) Selection of designated providers.** The bureau chief shall have sole authority to select designated providers. The bureau chief shall select which of the project plans received on or before the deadline date shall be granted the status of designated providers. The selection of designated providers shall be based upon the content of the project plan including, but not limited to, the following criteria:

1. Applicant's experience.
2. Geographic area selected and community need for the project.
3. Participants to be served and criteria to be used to select participants and terminate their participation.
4. The parenting curriculum to be used.
5. A description of the components of the curriculum.
6. The schedule, location, hours of instruction and format for administering the curriculum.
7. A description of the organization and identification of staff.
8. An explanation of monitoring and evaluation.
9. Project duration.

[ARC 3720C, IAB 3/28/18, effective 7/1/18]

**441—100.5(252B) Termination of designated providers.** The bureau chief may immediately terminate CSRU's participation with a designated provider if the designated provider is not fulfilling the terms of its project plan or the designated provider is not fulfilling the terms for CSRU's participation in the project plan.

[ARC 3720C, IAB 3/28/18, effective 7/1/18]

**441—100.6(252B) Reports and records.**

**100.6(1) Reports.** Designated providers established under these rules shall report to CSRU at least monthly, unless otherwise required by the project plan. These reports shall include, but not be limited to, the following:

- a.* Attendance documentation with the names of participants served.
- b.* Signed voluntary consent of participants seeking incentives.
- c.* Certification of participants completing the curriculum.
- d.* Other information as specified in the project plan.

**100.6(2) Records retention.** Designated providers shall retain all records as necessary to meet the requirements of these rules.

[ARC 3720C, IAB 3/28/18, effective 7/1/18]

**441—100.7(252B) Receipt of incentives.** Participants receiving incentives under these rules may continue to receive the incentives after the termination of these rules or after they are no longer participants only under subrule 100.2(1). Subrule 100.2(1) shall apply to a participant or former participant for the full time period allowed in that subrule.

[ARC 3720C, IAB 3/28/18, effective 7/1/18]

**441—100.8(17A) Right of appeal.** Department actions under this chapter are not subject to administrative appeal under 441—Chapter 7.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 5417C, IAB 2/10/21, effective 4/1/21]

These rules are intended to implement Iowa Code section 252B.3(5).

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[Filed ARC 5417C (Notice ARC 5274C, IAB 11/18/20), IAB 2/10/21, effective 4/1/21]

CHAPTER 187  
AFTERCARE SERVICES PROGRAM

PREAMBLE

These rules define and structure the aftercare services program, which assists youth leaving foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center in their successful transition to adulthood. The aftercare services program, including the preparation for adult living (PAL) program component, helps youth formerly in foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center to continue preparing for the challenges and opportunities presented by adulthood while receiving services and supports. The program offers services and financial benefits to eligible youth up to the age of 23. All services and supports are voluntary.

**441—187.1(234) Purpose.** The purpose of the aftercare services program is to provide services and supports to youth who are transitioning from foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center to adulthood. The primary goal of the program is for youth to move toward self-sufficiency and to recognize and accept their personal responsibility for the transition from adolescence to adulthood.

[ARC 4485C, IAB 6/5/19, effective 7/10/19]

**441—187.2(234) Aftercare services program eligibility requirements.** To be eligible for aftercare services, a youth must meet the following requirements:

**187.2(1) Residence.** The youth must be a resident of Iowa.

**187.2(2) Age.** The youth must be at least 17 years of age but less than 23 years of age. Program supports and services vary by age.

**187.2(3) Out-of-home placement experience.**

*a. Preservices.* The youth must meet eligibility requirements for preservices as described below:

- (1) The youth is at least 17 years of age; and
- (2) The youth was placed in foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center; was adopted after reaching 16 years of age; or entered a subsidized guardianship arrangement after reaching 16 years of age; and
- (3) The youth has access to funding for preservices provided in contract that has not been fully expended for the contract year.

*b. Core services.* The youth must meet eligibility requirements for core services as described below:

- (1) The youth is 18, 19, or 20 years of age; and
- (2) The youth exited foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center:
  1. On or after the youth's eighteenth birthday; or
  2. Between the ages of 17½ and 18 after having been in any combination of foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center for at least one day in at least 6 of the 12 calendar months prior to the youth leaving placement; or
  - (3) The youth was adopted from foster care on or after the youth's sixteenth birthday; or
  - (4) The youth entered a subsidized guardianship arrangement from foster care on or after the youth's sixteenth birthday.

*c. Extended services.* The youth must meet eligibility requirements for extended services as described below:

- (1) The youth resides in Iowa; and
- (2) The youth is 21 or 22 years of age; and
- (3) The youth was served by the aftercare services program prior to the age of 21; and
- (4) The youth has access to funding for extended services provided in contract that has not been fully expended for the contract year.

*d. Definition of foster care.* For purposes of this chapter, “foster care” is defined as 24-hour substitute care for a child who is placed away from the child’s parents or guardians and for whom the department or juvenile court services has placement and care responsibility through either a court order or voluntary agreement.

- (1) A placement may meet the definition of foster care regardless of whether:
  1. The placement is licensed and the state or a local agency makes payments for the child’s care;
  2. Adoption subsidy payments are being made before the finalization of adoption; or
  3. There is federal matching of any payments made.
- (2) Foster care may include, but is not limited to, placement in:
  1. A foster family home; or
  2. A foster care group home; or
  3. An emergency shelter; or
  4. A preadoptive home; or
  5. The home of a relative or suitable person; or
  6. A psychiatric medical institution for children (PMIC).

**187.2(4) Responsibility.** The youth must:

- a.* Actively take part in developing and participating in an individual self-sufficiency plan; and
- b.* Indicate recognition and acceptance of personal responsibility in the transition toward self-sufficiency, which includes, but is not limited to, meeting with the self-sufficiency advocate regularly and as described in the youth’s individual self-sufficiency plan, as described in subrule 187.3(2).

[ARC 4485C, IAB 6/5/19, effective 7/10/19; ARC 5420C, IAB 2/10/21, effective 4/1/21]

**441—187.3(234) Services and supports provided.** The aftercare services program shall provide the following services and supports to eligible youth:

**187.3(1) Preservices.** Planning, coordination of services, and trust-building activities may be provided to a youth placed out of home, as described in paragraph 187.2(3)“*a*,” who is expected to participate in aftercare services at 18 years of age or older. The administrator may provide funds as described in paragraph 187.3(4)“*a*.” However, funds provided to the youth in preservices will be deducted from available funds in the youth’s first year of participation in core services.

**187.3(2) Core services.** Case management services shall be offered to youth, as described in paragraph 187.2(3)“*b*,” at a safe and convenient location. Activities shall include, but not be limited to, all of the following:

*a.* Development of an individual self-sufficiency plan, based on an assessment of the youth’s strengths and needs. Each core services participant shall have a plan to identify:

- (1) The youth’s goals for achieving self-sufficiency;
- (2) The target date for reaching the goals; and
- (3) The tasks, responsible parties, time frames, and desired outcomes needed to reach the goals.

*b.* Services to develop a budget and money management skills training.

*c.* Services to assist the youth in establishing or reestablishing relationships with significant adults.

*d.* Services to facilitate the youth’s access to community resources.

*e.* Life skills training, as identified in the youth’s individual self-sufficiency plan. Life skills training shall include, but not be limited to, skills to help the youth in establishing and maintaining safe and stable housing; education goals; employment goals; health and health care coverage; and healthy relationships.

*f.* Additional case management activities necessary for youth to successfully transition to adulthood and as described in the individual self-sufficiency plan.

*g.* Individual face-to-face contact with the youth at the frequency defined in the youth’s individual self-sufficiency plan and according to the youth’s changing needs. If a youth is a resident of Iowa but is attending a postsecondary education program in another state, the program administrator or designee shall approve an alternative method for maintaining contact with the youth if and when it is a hardship for the youth to physically be in Iowa.

*h.* Ongoing assessment, including evaluation and coordination of the services, supports, and life skills training being provided to assist the youth in reaching self-sufficiency goals and to determine if and what progress is being made. The case manager shall amend any goals, outcomes, tasks, responsible parties, and time frames in the plan along with services, supports, and life skills training provided as necessary to assist the youth in achieving self-sufficiency.

**187.3(3) *Extended services.*** Extended services may be provided to youth, as described in paragraph 187.2(3)“c,” and may include, but are not limited to, life skills training, periodic check-in, referrals to needed services, and limited payments to youth. Funds, limited to an annual per-participant amount identified in the contract, may be provided to a former aftercare services participant. Prior to receiving available funds, the youth is required to meet with the advocate and discuss the reason the youth is accessing funds and prior efforts to meet the need. The youth may also be asked to provide documentation of income.

**187.3(4) *Start-up allowance.*** When a youth between the ages of 17 and 21 is receiving or is expected to receive core services in accordance with subrule 187.3(2), and is actively participating in the program, the program administrator or designee may authorize and provide payment to a youth as described below:

*a.* The start-up allowance is intended to assist in covering the initial costs of establishing the youth’s living arrangement, such as by paying rental or utility deposits, purchasing food, or purchasing necessary household items.

*b.* The start-up allowance is limited to \$600 per youth.

**187.3(5) *Vendor payments.*** When a youth qualifies for core services in accordance with subrule 187.3(2), and is actively participating in the program, the program administrator or designee may authorize and provide payment to a youth as described below:

*a.* To receive a vendor payment, the youth must demonstrate that there are no other means to meet the needs that would be covered by the vendor payment. The youth shall contribute toward the cost of meeting the identified need, to the extent the youth is able. A youth receiving a preparation for adult living (PAL) stipend, preservices or extended services is not eligible for a vendor payment.

*b.* Vendor payments may include, but are not limited to:

- (1) Health care-related expenses;
- (2) Transportation assistance;
- (3) Costs related to employment and education;
- (4) Clothing; and
- (5) Room and board.

*c.* The amount available for a 12-month period of service shall not exceed \$1,200 per youth.

**187.3(6) *Preparation for adult living (PAL) stipend.*** When an eligible youth is actively participating in the program, the administrator or designee shall deliver the preparation for adult living program as described in Iowa Code section 234.46 and as follows:

*a.* To be eligible for the PAL stipend, the youth must:

(1) Meet eligibility requirements in Iowa Code section 234.46 and rule 441—187.2(234); and

(2) Have been placed out of home in foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center as identified by Iowa Code chapter 232 on the youth’s eighteenth birthday and have exited after having been in any combination of the same services in at least 6 of the 12 months before leaving placement; and

(3) Be ineligible for voluntary foster care placement, due to one of the following:

1. The youth has a high school diploma or equivalent, or
2. The youth has reached 20 years of age, or
3. The youth became eligible for aftercare services due to exiting the Iowa state training school or an Iowa detention center, or
4. The youth became eligible for aftercare services due to exiting court-ordered care in accordance with Iowa Code chapter 232 by a relative or another person with a significant relationship with the youth.

*b.* To be eligible for the PAL stipend, the youth must meet one or more of the following criteria:

(1) Be enrolled in or actively pursuing enrollment in postsecondary education, a training program or work training; or

(2) Be employed for 80 hours per month or be actively seeking that level of employment; or  
 (3) Be attending an accredited school full-time pursuing a course of study leading to a high school diploma; or

(4) Be attending an instructional program leading to a high school equivalency diploma.

c. The maximum monthly stipend shall be provided after completion of the youth's budget. The maximum amounts provided to a youth shall be stated in the contract and shall be based on program eligibility and guidelines, as follows:

(1) The monthly stipend shall be prorated based on the number of days of youth participation, for those entering and exiting the program during the month.

(2) When the monthly unearned income of the youth exceeds the overall maximum monthly stipend offered in the preparation for adult living program, the youth is not eligible for payments under subrule 187.3(4) unless unused startup funds remain.

(3) When the net earnings of the youth exceed the overall maximum monthly stipend offered in the preparation for adult living program, the monthly stipend shall be reduced by 50 cents for every dollar earned by the youth over the overall monthly maximum stipend.

(4) All earned and unearned income received by the youth during the 30 days before the determination shall be used to project future income. If the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(5) Nonrecurring lump-sum payments are excluded as income. Nonrecurring lump-sum payments include, but are not limited to, one-time payments received for such things as income tax refunds, rebates, credits, refunds of security deposits on rental property or utilities, and retroactive payments for past months' benefits such as social security, unemployment insurance, or public assistance.

(6) The youth shall timely report the beginning and ending of earned and unearned income. A report shall be considered timely when made within ten days from the receipt of income or the date income ended.

(7) When the youth timely reports a change in income, the youth's prospective eligibility and stipend amount for the following month shall be determined based on the change.

(8) Recoupment shall be made for any overpayment due to failure to timely report a change in income or for benefits paid during an administrative appeal if the department's action is ultimately upheld. Recoupment may be made through a reasonable reduction of any future stipends.

(9) Recoupment shall not be made when a youth timely reports a change in income and the change is timely acted upon, but the timely notice policy in rule 441—16.3(17A) requires that the action be delayed until the second calendar month following the month of change.

(10) The stipend may be paid to the youth, the foster family, or another payee other than a department employee. The payee shall be agreed upon by the parties involved and specified in the individual self-sufficiency plan, described in subrule 187.3(2).

(11) The maximum stipend may be based on the age of the youth.

**187.3(7) Extended services allowance.** Youth 21 or 22 years of age who previously received aftercare services may receive extended services funds if they meet all of the following criteria:

a. The youth is participating in extended services as described in subrule 187.3(3).

b. A budget discussion has been completed timely by the youth with a self-sufficiency advocate.

c. The need has been identified in the individual self-sufficiency plan.

d. The extended services funds approved for the youth have not exceeded \$300 for a three-month period calculated from the date of initiation of extended services.

[ARC 4485C, IAB 6/5/19, effective 7/10/19; ARC 4973C, IAB 3/11/20, effective 4/15/20; ARC 5020C, IAB 4/8/20, effective 5/13/20; ARC 5420C, IAB 2/10/21, effective 4/1/21]

#### **441—187.4(234) Termination of aftercare services.**

**187.4(1)** A youth may be discharged from the aftercare services program for any of the following reasons:

- a. The youth fails to follow individual self-sufficiency plan components and expectations as determined by the program administrator or designee.
- b. The youth fails to meet regularly with the self-sufficiency advocate without good cause as determined by the program administrator or designee.
- c. The youth voluntarily withdraws from the program.
- d. The youth is no longer a resident of Iowa.
- e. The youth reaches 23 years of age.

**187.4(2)** Aftercare services and supports may be terminated for up to six months as determined by the program administrator or designee when a youth intentionally physically threatens or injures program staff or an employee of an aftercare provider agency.

**187.4(3)** The PAL stipend may be terminated if the youth fails to meet work or education eligibility requirements for 30 consecutive days without good cause as determined by the program administrator or designee.

**187.4(4)** The PAL stipend may be terminated if the youth fails to maintain satisfactory progress as defined by the education or training program in which the youth is enrolled. A youth who is not making satisfactory progress may stay in the PAL program component of the aftercare services program by choosing the work option specified in subparagraph 187.3(6)“b”(2). A PAL stipend or allowance shall not be reinstated for at least 30 days if the stipend was terminated for the reason described in this subrule.

**187.4(5)** The youth intentionally misrepresents income or expenditures or spends funds in a manner inconsistent with their intended purpose. The program administrator may request receipts or acceptable evidence that funds went to the intended purpose.

**187.4(6)** There are insufficient funds.

**187.4(7)** Unless otherwise stated, a youth whose aftercare service is terminated in accordance with this rule may return to the program after the passing of at least 30 days. However, if the youth has received three or more notices of termination within a 12-month period, the youth may not return until at least three months have passed from the date of the third notification.

[ARC 4485C, IAB 6/5/19, effective 7/10/19]

**441—187.5(234) Waiting list.** The program administrator or designee shall create a waiting list when all funds for the aftercare services program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible. Due to funding, it may be necessary to create more than one waiting list.

[ARC 4485C, IAB 6/5/19, effective 7/10/19]

**441—187.6(234) Administration.** The department may contract with another state agency or a private organization to perform the administrative and case management functions necessary to administer the aftercare services program. Agencies and organizations providing services or supports shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

[ARC 4485C, IAB 6/5/19, effective 7/10/19]

These rules are intended to implement Iowa Code section 234.46 and Public Law 106-169, the Foster Care Independence Act of 1999.

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CHAPTER 50  
HEALTH CARE FACILITIES ADMINISTRATION

**481—50.1(10A) Inspections.** The health facilities division inspects health care facilities, hospitals, and providers and suppliers of medical services in Iowa. Standards to obtain a license are explained in this chapter.

**481—50.2(10A) Definitions.**

*“Administrator”* means the person coordinating the administration of the division.

*“Department”* means the department of inspections and appeals.

*“Director”* means the director of inspections and appeals.

*“Division”* means the health facilities division.

**481—50.3(135B,135C) Licensing.** All hospitals and health care facilities shall be licensed by the department. Applications are available from the Health Facilities Division, Lucas State Office Building, Des Moines, Iowa 50319-0083. Completed applications are returned to the division with the fee.

**50.3(1)** Initial fees for hospitals are:

- a. Fifty beds or less, \$15;
- b. More than 50 and not more than 100 beds, \$25;
- c. Any greater number of beds, \$50.

A fee of \$10 is charged to renew a hospital license each year.

**50.3(2)** Initial and renewal fees for health care facilities are:

- a. Ten beds or less, \$20;
- b. More than 10 and not more than 25 beds, \$40;
- c. More than 26 and not more than 75 beds, \$60;
- d. More than 76 and not more than 150 beds, \$80;
- e. Any greater number of beds, \$100.

**50.3(3)** Standards used to determine whether a license is granted or retained are found in the rules of the department of inspections and appeals in the Iowa Administrative Code as follows:

- a. Hospitals, 481—Chapter 51;
- b. Hospices, 481—Chapter 53;
- c. Residential care facilities, 481—Chapters 57 and 60;
- d. Nursing facilities, 481—Chapters 58 and 61;
- e. Residential care facilities for persons with mental illness, 481—Chapters 60 and 62;
- f. Residential care facilities for the intellectually disabled, 481—Chapters 60 and 63;
- g. Intermediate care facilities for the intellectually disabled, 481—Chapter 64; and
- h. Intermediate care facilities for persons with mental illness, 481—Chapter 65.

**50.3(4)** Posting of license. The license shall be posted in each facility so the public can see it easily.  
[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—50.4(135C) Fines and citations.** A fine or citation will be issued and may be contested according to the rules in 481—Chapter 56.

**481—50.5(135C) Denial, suspension or revocation.**

**50.5(1)** A denial, suspension or revocation shall be effective 30 days after certified mailing or personal service of the notice.

**50.5(2)** A hearing may be requested and the request must be made in writing to the department within 30 days of the mailing or service.

**481—50.6(10A) Formal hearing.** All decisions of the division may be contested. Appeals and hearings are controlled by 481—Chapter 9, “Contested Cases.”

**50.6(1)** The proposed decision of the hearing officer becomes final ten days after it is mailed.

**50.6(2)** Any request for administrative review of a proposed decision must:

1. Be made in writing,
2. Be mailed by certified mail to the director, within ten days after the proposed decision was mailed to the aggrieved party,
3. State the reason(s) for the request.

A copy shall also be sent to the hearing officer at the Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.

**50.6(3)** The decision of the director shall be based upon the record and becomes final agency action upon mailing by certified mail.

**50.6(4)** The fees of witnesses for attendance and travel shall be the same as the fees for witnesses before the district court and shall be paid by the party to the proceeding at whose request the subpoena is issued.

[ARC 3523C, IAB 12/20/17, effective 1/24/18]

**481—50.7(10A,135C) Additional notification.** The director or the director’s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III):

**50.7(1)** Of any accident causing major injury.

*a.* “Major injury” shall be defined as any injury which:

- (1) Results in death; or
- (2) Requires admission to a higher level of care for treatment, other than for observation; or
- (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a “major injury” based upon the circumstances of the accident, the previous functional ability of the resident, and the resident’s prognosis.

*b.* The following are not reportable accidents:

- (1) An ambulatory resident, as defined in rules 481—57.1(135C), 481—58.1(135C), and 481—63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or
- (2) Spontaneous fractures; or
- (3) Hairline fractures.

**50.7(2)** When damage to the facility is caused by a natural or other disaster.

**50.7(3)** When there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury. For the purposes of this subrule, “pattern” means two or more times within a 30-day period.

**50.7(4)** When a resident elopes from a facility. For the purposes of this subrule, “elopes” means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff.

**50.7(5)** When a resident attempts suicide, regardless of injury.

**50.7(6)** When a fire occurs in a facility and the fire requires the notification of emergency services, require full or partial evacuation of the facility, or causes physical injury to a resident.

**50.7(7)** When a defect or failure occurs in the fire sprinkler or fire alarm system for more than 4 hours in a 24-hour period. (This reporting requirement is in addition to the requirement to notify the state fire marshal.)

NOTE: Additional reporting requirements are created by other rules and statutes, including but not limited to Iowa Code chapter 235B and 2008 Iowa Acts, House File 2591, which require reporting of dependent adult abuse.

**481—50.8(22,135B,135C) Records.** The division collects and stores a variety of records in the course of licensing and inspecting health care facilities. Some information stored may be personally identifiable. None is retrievable by personal identifier with the exception of a business which uses an individual’s name in the title. All records stored by the health facilities division are kept in files under the name of a facility. Computer files are retrieved by facility name also.

**50.8(1)** The department maintains information about long-term care facilities in files which are organized by facility name, city, and county. No information is retrievable by personal identifier. Each long-term care facility record contains both open and confidential information.

*a.* Open information includes:

- (1) License application and status,
- (2) Variance requests and responses,
- (3) Final findings of state and Medicaid survey investigations,
- (4) Records of complaints,
- (5) Reports from the fire marshal,
- (6) Plans of correction submitted by the facility,
- (7) Medicaid status,
- (8) Official notices of license and Medicaid sanctions.

*b.* Confidential information includes:

- (1) Survey or investigation information which does not comprise a final finding. Survey information which does not comprise a final finding may be made public in a proceeding concerning the citation of a facility, denial, suspension or revocation of a license, Iowa Code section 135C.19(1),
- (2) Names of all complainants, Iowa Code sections 135C.19(1) and 135C.37,
- (3) Names of patients in all facilities, identifying medical information and the address of anyone other than an owner, Section 1106 of the Social Security Act as amended, 42 CFR Part 401, Subpart B (October 1, 1986) and Iowa Code sections 22.9 and 135C.19(1).

**50.8(2)** The department maintains records about hospitals. The records are organized by facility name, city, and county. The records are not retrievable by personal identifier. The Joint Commission on the Accreditation of Healthcare Organizations is referred to as JCAHO, and the American Osteopathic Association is referred to as AOA in this rule. These records may contain both open and confidential information.

*a.* Open information includes:

- (1) License status,
- (2) Medicare certification status,
- (3) Medicare survey reports,
- (4) Plans of correction submitted by a hospital,
- (5) Official notices of involuntary provider termination or license sanctions,
- (6) For hospitals not certified by JCAHO or AOA, reports of the fire marshal,
- (7) Final survey findings of the JCAHO and the AOA with respect to compliance by a hospital with the requirements for licensure or accreditation.

*b.* Confidential information includes:

- (1) Names of patients and identifying medical information,
- (2) Identity of any complainant, and
- (3) The address of anyone other than the owner, Iowa Code section 135B.12 and Section 1106 of the Social Security Act, 42 CFR Part 401, Subpart B (October 1, 1986) and Iowa Code section 22.9.
- (4) Rescinded IAB 2/19/92, effective 3/25/92.
- (5) No information may be disclosed in a manner which will identify individuals or hospitals except in a proceeding concerning the question of license or the denial, suspension or revocation of a license, Iowa Code section 135B.12.

**50.8(3)** The department maintains files for all other Medicare-certified facilities. These files are organized by facility or agency name, city, and county. None is retrievable by personal identifier except when a business uses an individual's name in its title. These files contain both open and confidential information.

*a.* Open information includes:

- (1) Certification status,
- (2) Survey reports,
- (3) Plans of correction,
- (4) Official notices of involuntary provider termination,

(5) Proficiency test results for non-JCAHO or AOA accredited hospitals, Medicare laboratories and laboratories licensed under the clinical Laboratory Improvement Act.

*b.* Confidential information includes:

- (1) Name of any patient,
- (2) Medical information about any identifiable patient,
- (3) The identity of any complainant, and
- (4) The address of anyone other than an owner of the facility, Section 1106 of the Social Security Act, 43 CFR, Part 401, Subpart B (October 1, 1986), and Iowa Code section 22.9.

**50.8(4)** Rescinded IAB 3/31/04, effective 5/5/04.

**50.8(5)** Following a written request and payment of a fee in the amount determined by the department, one or more of the following lists may be obtained by the public.

*a.* Corporations which own more than one facility and the list of facilities owned by each corporation.

*b.* All the facilities in the state with the owner of the real estate property identified.

*c.* All corporations that lease facilities and the facilities they lease.

*d.* All corporations which manage facilities for other owners and the facilities they manage.

Requests are sent to Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.

#### **481—50.9(135C) Criminal, dependent adult abuse, and child abuse record checks.**

**50.9(1) Definitions.** The following definitions apply for the purposes of this rule.

*“Background check”* or *“record check”* means criminal history, child abuse and dependent adult abuse record checks.

*“Certified nurse aide training program”* means a program approved in accordance with the rules for such programs adopted by the department of human services for the training of persons seeking to be a certified nurse aide for employment in a facility as defined by this rule or in a hospital as defined in Iowa Code section 135B.1.

*“Comprehensive preliminary background check”* means a criminal history check of all states in which the applicant has worked or resided over the seven-year period immediately prior to submitting an application for employment or participation in a certified nurse aide training program that is conducted by an approved third-party vendor.

*“Direct services”* means services provided through person-to-person contact. “Direct services” excludes services provided by individuals such as building contractors, repair workers, or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and who do not provide any treatment or services for residents, patients, tenants, or participants of the provider.

*“Employed in a facility”* or *“employment within a facility”* means all of the following if the provider is regulated by the state or receives any federal or state funding:

1. An employee of a health care facility licensed under Iowa Code chapter 135C if the employee provides direct or indirect services to residents;
2. An employee of a home health agency if the employee provides direct services to consumers;
3. An employee of a hospice if the employee provides direct services to consumers.

*“Employee”* means any individual who is paid either by the facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors).

*“Evaluation”* means review by the department of human services to determine whether a founded child abuse, dependent adult abuse or criminal conviction warrants prohibition of the person’s employment in a facility; or whether a founded child abuse, dependent adult abuse or criminal conviction warrants prohibition of a student’s involvement in a clinical education component of the certified nurse aide training program involving children or dependent adults.

*“Facility,”* for purposes of this rule, means all of the following if the provider is regulated by the state or receives any federal or state funding:

1. A health care facility licensed under Iowa Code chapter 135C;
2. A home health agency;

3. A hospice.

*“Indirect services”* means services provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance.

*“Student”* means a person applying for, enrolled in, or returning to a certified nurse aide training program.

**50.9(2)** *Explanation of “crime.”* For purposes of this rule, the term “crime” does not include offenses under Iowa Code chapter 321 classified as simple misdemeanor or equivalent simple misdemeanor offenses from another jurisdiction.

**50.9(3)** *Requirements for employer prior to employing an individual.* Prior to employment of a person in a facility, the facility shall complete the background check requirements set forth below.

*a. Informing the prospective employee.* A facility shall ask each person seeking employment by the facility, “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime other than a simple misdemeanor offense relating to motor vehicles and laws of the road under Iowa Code chapter 321 or equivalent provisions, in this state or any other state?” In addition, the person shall be informed that a background check will be conducted. The person shall indicate, by signature, that the person has been informed that the background check will be conducted. (I, II, III)

*b. Conducting a background check.* The facility shall either request that the department of public safety perform a criminal history check and that the department of human services perform child and dependent adult abuse record checks of the person in this state, or access the single contact repository (SING) to perform the required background check. If the SING is used, the facility shall submit the person’s maiden name, if applicable, with the background check request. (I, II, III)

*c. If a person being considered for employment has been convicted of a crime.* If a person being considered for employment in a facility has been convicted of a crime under a law of any state, the facility shall request that the department of human services perform an evaluation to determine whether the crime warrants prohibition of the person’s employment in the facility. (I, II, III)

*d. If a person being considered for employment has a record of founded child or dependent adult abuse.* If a person being considered for employment in a facility has a record of founded child or dependent adult abuse under a law of any state, the facility shall request that the department of human services perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of the person’s employment in the facility. (I, II, III)

*e. Employment pending evaluation.* The facility may provisionally employ a person prior to completion of the required record check and evaluation by the department of human services, as applicable, subject to all of the following:

(1) The facility shall have accessed SING to perform the required record check and be awaiting results from SING or awaiting evaluation by the department of human services, as applicable;

(2) If applicable, the facility shall request an evaluation by the department of human services in accordance with paragraph 50.9(3) “c” or “d” within 30 days of receipt of the SING record check results;

(3) The facility shall have utilized an approved third-party vendor to perform a comprehensive preliminary background check;

(4) If the comprehensive preliminary background check determines that the person being considered for employment has been convicted of a crime, the crime does not constitute a felony as defined in Iowa Code section 701.7 and is not a crime specified pursuant to Iowa Code chapter 708, 708A, 709, 709A, 710, 710A, 711, or 712 or pursuant to Iowa Code section 726.3, 726.7, or 726.8;

(5) The comprehensive preliminary background check shall have determined that the person being considered for employment does not have a record of founded child abuse or dependent adult abuse, or, if the person being considered for employment does have a record of founded child abuse or dependent adult abuse, subrule 50.9(8) is applicable; and

(6) The provisional employment may continue until such time as the required record check through SING and evaluation by the department of human services, as applicable, are completed. (I, II, III)

**50.9(4)** *Validity of background check results.* The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the facility. (I, II, III)

**50.9(5) *Employment prohibition.*** Except as provided in paragraph 50.9(3)“e,” a person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a facility unless an evaluation has been performed by the department of human services. (I, II, III)

**50.9(6) *Transfer of an employee to another facility owned or operated by the same person.*** If an employee transfers from one facility to another facility owned or operated by the same person, without a lapse in employment, the facility is not required to request additional criminal and child and dependent adult abuse record checks of that employee. (I, II, III)

**50.9(7) *Transfer of ownership of a facility.*** If the ownership of a facility is transferred, at the time of transfer the background check required by this rule shall be performed for each employee for whom there is no documentation that such background check has been performed. The facility may continue to employ such employee pending the performance of the background check and any related evaluation. (I, II, III)

**50.9(8) *Change of employment—person with criminal or abuse record—exception to record check evaluation requirements.*** A person with a criminal or abuse record who is or was employed by a facility and is hired by another facility shall be subject to the background check.

*a.* A reevaluation of the latest record check is not required, and the person may commence employment with the other facility if the following requirements are met:

(1) The department of human services previously performed an evaluation concerning the person’s criminal or abuse record and concluded the record did not warrant prohibition of the person’s employment;

(2) The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the previous evaluation;

(3) 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;

(4) Any restrictions placed on the person’s employment in the previous evaluation by the department of human services and still applicable shall remain applicable in the person’s subsequent employment; and

(5) The person subject to the background check has maintained a copy of the previous evaluation and provided it 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 current record check evaluation shall be performed. (I, II, III)

*b.* For purposes of this subrule, a position is “substantially the same or has the same job responsibilities” if the position requires the same certification, licensure, or advanced training. For example, a licensed nurse has substantially the same or the same job responsibilities as a director of nursing; a certified nurse aide does not have substantially the same or the same job responsibilities as a licensed nurse.

*c.* The subsequent employer must maintain the previous evaluation in the employee’s personnel file for verification of the exception to the requirement for a record check evaluation. (I, II, III)

*d.* The subsequent employer may request a reevaluation of the background check and may employ the person while the reevaluation is being performed, even though an exemption under paragraph 50.9(8)“a” may be authorized.

**50.9(9) *Employee notification of criminal conviction or founded abuse after employment.*** If a person employed by a facility employer that is subject to this rule is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person’s employment application date, the person shall inform the employer of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

*a.* The employer shall act to verify the information within seven calendar days of notification. “Verify,” for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search

through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

*b.* If the information is verified, the facility shall follow the requirements of paragraphs 50.9(3) “*c*” and “*d.*” (I, II, III)

*c.* The employer may continue to employ the person pending the performance of an evaluation by the department of human services.

*d.* A person who is required by this subrule to inform the person’s employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

*e.* The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under this subrule.

**50.9(10)** *Facility receipt of credible information that an employee has been convicted of a crime or has a record of founded abuse.* If the facility receives credible information, as determined by the facility, from someone other than the employee, that the employee has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment, and the employee has not informed the employer of the information within the time required by subrule 50.9(9), the facility shall take the following actions:

*a.* The facility shall act to verify credible information within seven calendar days of receipt. “Verify,” for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

*b.* If the information is verified, the facility shall follow the requirements of paragraphs 50.9(3) “*c*” and “*d.*” (I, II, III)

**50.9(11)** *Proof of background checks for temporary employment agencies and contractors.* Proof of background checks may be kept in the files maintained by temporary employment agencies and contractors. Facilities may require temporary employment agencies and contractors to provide a copy of the result of the background checks. Copies of such results shall be made available to the department upon request. (I, II, III)

**50.9(12)** *Certified nurse aide training program students.* Prior to a student’s beginning or returning to a certified nurse aide training program, the program shall either request that the department of public safety perform a criminal history check and that the department of human services perform child and dependent adult abuse record checks of the person in this state, or access the SING to perform the required background check.

*a.* *Prohibition of involvement in clinical education.* Except as provided in paragraph 50.9(1) “*b.*,” if a student has a criminal record or a record of founded child or dependent adult abuse, the student shall not be involved in a clinical education component of the certified nurse aide training program involving children or dependent adults unless an evaluation has been performed by the department of human services. The evaluation shall be performed upon request of the certified nurse aide training program.

*b.* *Involvement in clinical education component pending evaluation.* The training program may provisionally allow the student’s participation in the clinical education component of the certified nurse aide training program pending completion of the required record check and evaluation by the department of human services, as applicable, subject to all of the following:

(1) The training program shall have accessed SING to perform the required record check and be awaiting results from SING or awaiting evaluation by the department of human services, as applicable;

(2) If applicable, the training program shall request an evaluation by the department of human services in accordance with paragraph 50.9(12) “*a.*” within 30 days of receipt of the SING record check results;

(3) The training program shall have utilized an approved third-party vendor to perform a comprehensive preliminary background check;

(4) If the comprehensive preliminary background check determines that the student being considered for participation has been convicted of a crime, the crime does not constitute a felony as defined in Iowa Code section 701.7 and is not a crime specified pursuant to Iowa Code chapter 708, 708A, 709, 709A, 710, 710A, 711, or 712 or pursuant to Iowa Code section 726.3, 726.7, or 726.8;

(5) The comprehensive preliminary background check shall have determined that the student does not have a record of founded child abuse or dependent adult abuse, or, if the student does have a record of founded child abuse or dependent adult abuse, subrule 50.9(8) is applicable; and

(6) The provisional participation may continue until such time as the required record check through SING and evaluation by the department of human services, as applicable, are completed.

*c. Student notification of criminal conviction or founded abuse after performance of record checks and evaluation.* If a student is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the record checks and any evaluation have been performed, the student shall inform the certified nurse aide training program of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

(1) The program shall act to verify the information within seven calendar days of notification. “Verify,” for purposes of this paragraph, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents. If the information is verified, the program shall follow the requirements of paragraph 50.9(12) “a” to determine whether or not the student’s involvement in a clinical education component may continue.

(2) The program may allow the student involvement to continue pending the performance of an evaluation by the department of human services.

(3) A student who is required to inform the program of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

(4) The program may notify the county attorney for the county where the program is located of any violation or failure by a student to notify the program of a criminal conviction or entry of an abuse record within the period required by this paragraph.

*d. Program receipt of credible information that a student has been convicted of a crime or has a record of founded abuse.* If a program receives credible information, as determined by the program, that a student has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after the record checks and any evaluation have been performed, from a person other than the student, and the student has not informed the program of such information within 48 hours, the program shall act to verify the credible information within seven calendar days of receipt of the credible information. “Verify,” for purposes of this paragraph, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents. If the information is verified, the requirements of paragraph 50.9(12) “a” shall be applied to determine whether or not the student’s involvement in a clinical education component may continue.

*e. Completion of a certified nurse aide training program conducted by the health care facility.* If a certified nurse aide training program is conducted by the facility and a student of that program accepts and begins employment with the facility within 30 days of completing the program, the background check of the student performed prior to beginning the training program shall fulfill the criminal and

abuse background check requirements. The facility shall maintain the proof required in subrule 50.9(11). (I, II, III)

This rule is intended to implement Iowa Code sections 135C.14 and 135C.33.  
[ARC 0903C, IAB 8/7/13, effective 9/11/13; ARC 1566C, IAB 8/6/14, effective 9/10/14; ARC 5421C, IAB 2/10/21, effective 3/17/21]

**481—50.10(135C) Inspections, exit interviews, plans of correction, and revisits.**

**50.10(1) *Frequency of inspection.*** The department shall inspect a licensed health care facility at least once within a 30-month period. Facilities participating in the Medicare or Medicaid programs may be inspected more frequently as a part of a joint state and federal inspection.

**50.10(2) *Accessibility of records, the facility, and persons.*** An inspector of the department may enter any licensed health care facility without a warrant and may examine all records pertaining to the care provided to residents of the facility. An inspector of the department may contact or interview any resident, employee, or any other person who might have knowledge about the operation of a health care facility. The inspector may duplicate records and take photographs as part of the inspection.

**50.10(3) *Exit interviews.*** The health care facility shall be provided an exit interview at the conclusion of an inspection, and the facility representative shall be informed of all issues and areas of concern related to the deficiencies.

*a. Methods of conducting exit interview.* The department may conduct the exit interview either in person or by telephone.

*b. Second exit interviews.* The department shall conduct a second exit interview if any additional areas of concern are identified.

**50.10(4) *Submission of additional or rebuttal information.*** The facility shall be provided two working days from the date of the exit interview to submit additional or rebuttal information to the department.

*a. Receipt of additional information.* Additional or rebuttal information must be received by the department within two working days in order to be considered.

*b. Methods to submit additional information.* The additional or rebuttal information may be submitted via email, facsimile, or overnight courier to the department.

*c. Inform of the opportunity to submit additional or rebuttal information.* During the inspection, the facility shall be informed of the opportunity to submit additional or rebuttal information and of the contact information for the department.

**50.10(5) *Standards for determining whether a deficiency exists.*** The department shall use a preponderance of the evidence standard when determining whether a regulatory deficiency exists. For purposes of this rule and rule 481—50.11(135C), “preponderance of the evidence standard” means that the evidence, considered and compared with the evidence opposed to it, produces the belief in a reasonable mind that the allegations or deficiency is more likely true than not true. This standard does not require that the inspector personally witnessed the alleged violation.

**50.10(6) *Statement of deficiencies.*** When one or more deficiencies are found, a statement of deficiencies detailing each deficiency shall be sent by the department to the health care facility within ten working days of the exit interview.

**50.10(7) *Plan of correction.*** Within ten calendar days following receipt of the statement of deficiencies, the health care facility shall submit a plan of correction to the department.

*a. Contents of plan.* The plan of correction shall contain the following information:

- (1) How the facility will correct the deficient practice;
- (2) How the facility will act to protect residents;
- (3) The measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- (4) How the facility plans to monitor its performance to make sure that solutions are sustained; and
- (5) Date(s) when corrective action will be completed.

*b. Review of plan.* The department shall review the plan of correction within ten working days of receipt. The department may request additional information or revisions to the plan, which shall be provided as requested.

**50.10(8) Revisits.** If a facility licensed under this chapter is subject to or will be subject to denial of payment including payment for Medicare or medical assistance (Medicaid) under Iowa Code chapter 249A, or denial of payment for all new admissions pursuant to 42 CFR Section 488.417, and submits a plan of correction relating to the deficiencies or a response to a citation issued under 481—Chapter 56 and the department elects to conduct an on-site revisit inspection, the department shall commence the revisit inspection within the shortest time feasible of the date that the plan of correction is received or the date specified within the plan of correction alleging compliance, whichever is later.

**50.10(9) Appeals of statement of deficiencies.** The facility may appeal the statement of deficiencies by filing an appeal request with the department within 20 working days after receipt of the statement of deficiencies. The procedures defined in rule 481—50.6(10A) shall be followed for the appeal.

[ARC 8433B, IAB 12/30/09, effective 2/3/10; ARC 1566C, IAB 8/6/14, effective 9/10/14]

**481—50.11(135C) Complaint and self-reported incident investigation procedure.**

**50.11(1) Complaint.** The process for filing a complaint is as follows:

*a.* Any person with concerns regarding a facility may file a complaint with the Department of Inspections and Appeals, Complaint/Incident Bureau, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; by use of the complaint hotline, 1-877-686-0027; by facsimile sent to (515)281-7106; or through the website address [dia-hfd.iowa.gov/DIA\\_HFD/Home.do](http://dia-hfd.iowa.gov/DIA_HFD/Home.do).

*b.* When the nature of the complaint is outside the department's authority, the department shall forward the complaint or refer the complainant to the appropriate investigatory entity.

*c.* The complainant shall include as much of the following information as possible in the complaint: the complainant's name, address and telephone number; the complainant's relationship to the facility or resident; and the reason for the complaint.

*d.* The complainant's name shall be confidential information and shall not be released by the department.

*e.* The department shall act on anonymous complaints unless the department determines that the complaint is intended to harass the facility.

*f.* If the department, upon preliminary review, determines that the complaint is intended as harassment or is without a reasonable basis, the department may dismiss the complaint.

**50.11(2) Self-reported incident.** When the facility is required pursuant to rule 481—50.7(10A,135C) or other requirements to report an incident, the facility shall make the report to the department via:

*a.* The web-based reporting tool accessible from the following Internet site, [dia-hfd.iowa.gov/DIA\\_HFD/Home.do](http://dia-hfd.iowa.gov/DIA_HFD/Home.do), under the "Login" tab and then access "Add self report";

*b.* Mail by sending the self-report to the Department of Inspections and Appeals, Complaint/Incident Bureau, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083;

*c.* The complaint/incident hotline, 1-877-686-0027; or

*d.* Facsimile sent to (515)281-7106.

**50.11(3) Time frames for investigation of complaint or self-reported incident.** The following guidelines shall be used for determining the time frame in which an on-site inspection of the facility shall be initiated:

*a. Immediate jeopardy situation.* Within 2 working days for a complaint or self-reported incident determined by the department to be an alleged immediate jeopardy situation. For purposes of this rule, "immediate jeopardy situation" means a situation in which the facility's alleged noncompliance with Iowa Code chapter 135C, or rules adopted pursuant thereto, has caused or is likely to cause, serious injury, harm, impairment, or death to a resident.

*b. High-level nonimmediate jeopardy situation.* Within 10 days for nursing facilities and within 20 working days for intermediate care facilities and residential care facilities for a complaint or self-reported incident determined by the department to be an alleged high-level nonimmediate jeopardy situation. For purposes of this rule, "high-level nonimmediate jeopardy situation" means the alleged noncompliance with Iowa Code chapter 135C, or rules adopted pursuant thereto, may have caused harm that negatively

impacts the resident's mental, physical, or psychosocial status and is of such consequence to the resident's well-being that a rapid response is warranted.

*c. Other nonimmediate jeopardy situation.* Within 45 calendar days for a complaint or self-reported incident determined by the department to be an alleged nonimmediate jeopardy situation, other than a high-level nonimmediate jeopardy situation. For purposes of this rule, "other nonimmediate jeopardy situation" means a situation that is not a high-level nonimmediate jeopardy situation where the alleged noncompliance with Iowa Code chapter 135C, or rules adopted pursuant thereto, may cause harm of limited consequence and does not significantly impair the individual's mental, physical, or psychosocial status or function.

*d. No inspection of facility-reported incidents.* The department may determine not to institute an inspection of a self-reported incident using criteria including, but not limited to, the following:

(1) There is no evident deficiency on the part of the facility, and the facility has taken appropriate measures to address the situation; or

(2) There is a potential deficiency but:

1. The facility has taken appropriate measures to address the situation;

2. The facility does not have a recent history of identified deficiency similar to or related to the incident being reported;

3. A complaint has not been filed regarding the incident being reported; and

4. The resulting injury does not cause a significant negative impact to the resident's quality of life.

**50.11(4) Standard for determining whether a complaint or self-reported incident is substantiated.** The department shall apply a preponderance of the evidence standard in determining whether a complaint or self-reported incident is substantiated.

**50.11(5) Notification of program and complainant.** The department shall notify the facility and, if known, the complainant of the findings of the complaint investigation. The department shall also notify the complainant, if known, if the department does not investigate a complaint, and the reasons for not investigating the complaint shall be included in the notification.

**50.11(6) Process for complaint and self-reported incident.** The department and facility shall follow the process outlined in rule 481—50.10(135C), as applicable, when conducting or responding to a complaint or self-reported incident investigation.

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

**481—50.12(135C) Requirements for service.** At each inspection, the facility shall provide the most current contact information for the purpose of service of departmental notices. A statement of deficiencies or citation shall be served upon a facility using one of the following methods.

**50.12(1) Electronic mail.** If a facility has electronic mail, electronic mail shall be used for service of statements of deficiencies and citations. If electronic mail is used, the following shall be complied with:

*a.* The department shall send the electronic message return receipt requested. The response from the return receipt shall officially document receipt of the service and the date of receipt.

*b.* A facility shall allow the electronic return receipt to be returned to the department and shall not delay the sending of the return receipt.

*c.* If the department has not received the return receipt within three business days of sending the service via electronic mail, the department shall contact the facility to verify the receipt of the service.

**50.12(2) Certified mail.** If a facility does not have access to electronic mail, the service shall be sent via certified mail, return receipt requested.

**50.12(3) Personal service.** The department may choose to personally serve the notice upon the health care facility by delivering a copy of the statement of deficiencies or citation to the health care facility and presenting the copy to the facility.

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

**481—50.13(135C) Inspectors' conflicts of interest.**

**50.13(1) Conflicts.** Any of the following circumstances disqualifies an inspector from inspecting a particular health care facility licensed under Iowa Code chapter 135C:

*a.* The inspector currently works or, within the past two years, has worked as an employee or employment agency staff at the health care facility, or as an officer, consultant, or agent for the health care facility to be inspected.

*b.* The inspector has any financial interest or any ownership interest in the facility. For purposes of this paragraph, indirect ownership, such as through a broad-based mutual fund, does not constitute a financial or ownership interest.

*c.* The inspector has an immediate family member who has a relationship with the facility as described in subrule 50.13(1), paragraphs “*a*” and “*b*.”

**50.13(2) Immediate family member.** For purposes of this rule, “immediate family member” means the same as set forth in 42 CFR 488.301, and includes a husband or wife; natural or adoptive parent, child, or sibling; stepparent, stepchild, or stepsibling; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; or grandparent or grandchild.

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

These rules are intended to implement Iowa Code sections 22.11 and 135B.3 to 135B.7 and Iowa Code chapters 10A and 135C.

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## CHAPTER 51 HOSPITALS

[Prior to 12/14/88, see Health Department[470] Ch 51]

[Prior to 8/8/90, see Public Health[641] Ch 51]

**481—51.1(135B) Definitions.** As used in this chapter, unless the context otherwise requires, the following definitions apply:

*“Critical access hospital”* means any hospital located in a rural area and certified by the Iowa department of public health as being a necessary provider of health care services to residents of the area. A “critical access hospital” makes available 24-hour emergency care, is a designated provider in a rural health network, and meets the criteria specified pursuant to 481—51.53(135B). If swing-bed approval has been granted, all 25 beds may be used interchangeably for acute or skilled nursing facility level of care services.

*“Department”* means the Iowa department of inspections and appeals.

*“Governing board”* means the board of trustees, the owner or the person or persons designated by the owner as the governing authority who shall have supreme authority in the hospital and be responsible for the management, control, and appointment of the medical staff.

*“Governmental unit”* means the state, or any county, municipality, or other political subdivision, or any department, division, board or other agency of any of the foregoing.

*“Hospital”* or *“general hospital”* means an institution, place, building, or agency represented and held out to the general public as ready, willing and able to furnish care, accommodations, facilities and equipment for the diagnosis or treatment, over a period exceeding 24 hours, of two or more nonrelated individuals suffering from illness, injury, infirmity or deformity, or other physical or mental condition for which medical, surgical and obstetrical care services are provided. The term “hospital” does not include the following:

1. Any institution for well children, day nursery and child care center, foster boarding homes or houses, and homes for disabled children. However, such institutions that have a dual function, including nursing and medical care, and care of the sick are required to be licensed.
2. Homes, houses or institutions for aged persons which limit their functions to room and board and provide no medical or nursing care and house no bedridden person.
3. Dispensary or first-aid stations maintained for the care of employees, students, customers, and members of any commercial or industrial plant, educational institution, or convent.

*“Long-term acute care hospital”* means any hospital that has an average inpatient length of stay greater than 25 days, and that provides extended medical and rehabilitative care for patients who are clinically complex and who may suffer from multiple acute or chronic conditions. Services provided by a long-term acute care hospital include but are not limited to comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. A long-term acute care hospital shall meet the requirements for a general hospital including emergency services, except that obstetrical facilities are not required, and, if the long-term acute care hospital is located within a separately licensed hospital and does not provide its own emergency services, the long-term acute care hospital shall contract for emergency services with the host general hospital.

*“Medical staff”* means an organized body that is composed of individuals appointed by the hospital governing board, that operates under bylaws approved by the governing board and that is responsible for the quality of medical care provided to patients by the hospital. All members of the medical staff, one of whom shall be a licensed physician, shall be licensed to practice in the state of Iowa.

*“Premises”* means any or all designated portions of a building or structure, enclosures or places in the building, or real estate when the distinct and clearly identifiable parts provide separate care and services. The definition of “premises” shall not be construed to permit the existence of a separately licensed specialty hospital within the physical structure of a general hospital. A specialty hospital shall be defined pursuant to 42 CFR Section 411.351 and any amendments thereto, or pursuant to any regulations promulgated by the Secretary of Health and Human Services.

“*Specialized hospital*” means any hospital devoted primarily to the specialized care and treatment of persons with chronic or long-term illness, injury, or infirmity. The diagnosis, treatment or care shall be administered by or performed under the direction of persons especially qualified in the diagnosis and treatment of the particular illness, injury, or infirmity. A specialized hospital shall meet the requirements for a general hospital. “Specialized hospital” as defined in this rule does not include a specialty hospital defined pursuant to 42 CFR Section 411.351.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

#### **481—51.2(135B) Classification, compliance and license.**

**51.2(1)** Classification. For the purpose of administering the hospital licensing law, all institutions subject to licensure shall be classified as a critical access hospital, general hospital, long-term acute care hospital, or specialized hospital. The license issued by the department shall clearly identify the classification of the hospital.

**51.2(2)** Compliance requirements for each classification. A hospital shall comply with all of the general regulations for hospitals and shall comply with regulations pertaining to specialized services, if specialized services are provided in the hospital.

**51.2(3)** Separate license required. A separate license shall be required for each hospital even though more than one is operated under the same management. A separate license is not required for separate buildings of a hospital located on separate parcels of land, which are not adjoining but provide elements of the hospital’s full range of services for the diagnosis, care, and treatment of human illness, including convalescence and rehabilitation, and which are organized under a single owner or governing board with a single designated administrator and medical staff.

**51.2(4)** Posting of license. The license shall be conspicuously posted on the main premises of the hospital.

**51.2(5)** The department shall recognize, in lieu of its own licensure inspection, the comparable inspections and inspection findings of The Joint Commission (TJC), the American Osteopathic Association (AOA), DNV GL – Healthcare (DNV GL), or the Center for Improvement in Healthcare Quality (CIHQ) if the department is provided with copies of all requested materials relating to the inspection process. In cases of the initial licensure, the department may require its own inspection when needed in addition to comparable accreditations to allow the hospital to begin operations. The department may also initiate its own inspection when it is determined that the inspection findings of TJC, AOA, DNV GL, or CIHQ are insufficient to address concerns identified as possible licensure issues.

**51.2(6)** Hospitals not accredited by TJC, AOA, DNV GL, or CIHQ shall be inspected by the department utilizing the current Medicare conditions of participation found in Title XVIII of the federal Social Security Act and 42 CFR Part 482, Subparts A, B, C, D, and E, or 42 CFR Part 485, Subpart F. Licensed-only hospitals shall be inspected utilizing the requirements of this chapter. The department may promulgate additional standards. The department may recognize, in lieu of its own licensure inspection, the comparable inspection and inspection findings of a Medicare conditions of participation survey.

This rule is intended to implement Iowa Code chapter 135B.

[ARC 9253B, IAB 12/1/10, effective 1/5/11; ARC 1305C, IAB 2/5/14, effective 3/12/14; ARC 2472C, IAB 3/30/16, effective 5/4/16]

#### **481—51.3(135B) Quality improvement program.**

**51.3(1)** There shall be an ongoing hospitalwide quality improvement program. This program is to be designed to improve, as needed, the quality of patient care by:

- a. Assessing clinical patient care;
- b. Assessing nonclinical and patient-related services within the hospital;
- c. Developing remedial action as needed; and
- d. Ongoing monitoring and evaluating of the progress of remedial action taken.

**51.3(2)** The governing body shall ensure there is an effective hospitalwide patient-oriented quality improvement program.

**51.3(3)** The quality improvement program shall involve active participation of physician members of the hospital's medical staff and other health care professionals, as appropriate. Evidence of this participation will include ongoing case review and assessment of other patient care problems which have been identified through the quality improvement process.

**51.3(4)** The quality improvement plan may include external, state, local, federal, and regional benchmarking activities designed to improve the quality of patient care. The quality improvement plan shall be written and may address the following:

- a. The program's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities;
- b. The participation from all departments, services (including services provided both directly and under contract), and disciplines;
- c. An assessment of participation through a quality improvement committee meeting on an established periodic basis;
- d. The coordination of quality improvement activities;
- e. The communication, reporting and documentation of all quality improvement activities on a regular basis to the governing board, the medical staff, and the hospital administrator;
- f. An annual evaluation by the governing board of the effectiveness of the quality improvement program; and
- g. The accessibility and confidentiality of materials relating to, generated by or part of the quality improvement process.

This rule is intended to implement Iowa Code chapter 135B.  
[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.4(135B) Long-term acute care hospital located within a general hospital.**

**51.4(1)** If a long-term acute care hospital occupies the same building, premises or physical location of a general hospital, all treatment facilities and administrative offices for each hospital shall be clearly marked and separated from each other, and located within the licensed premises of each licensee.

- a. Treatment facilities shall be sufficient to meet the medical needs of the patients.
- b. Administrative offices shall include, but not be limited to, record rooms and personnel offices.
- c. There shall be clearly identifiable and distinguishable signs for each hospital.

**51.4(2)** If a long-term acute care hospital occupies the same building, premises or physical location of a general hospital, each hospital shall have its own entrance. The separate entrance shall have appropriate signs and shall be clearly identifiable as belonging to a particular hospital. Nothing shall prohibit a long-term acute care hospital that is occupying the same building, premises or physical location as a general hospital from utilizing the entrance, hallway, stairs, elevators or escalators of the general hospital to provide access to the long-term acute care hospital's separate entrance.

**51.4(3)** A long-term acute care hospital located within a general hospital shall have sufficient staff to meet the patients' needs. No nursing services staff of either the long-term acute care hospital or the host general hospital shall be simultaneously assigned patient duties in both licensed hospitals.

**51.4(4)** Each long-term acute care hospital located within a general hospital and the host general hospital shall have a separate and distinct governing board, which shall be in control of the respective hospital. No more than one board member shall serve in a common capacity on the governing board of each licensed hospital. For the purposes of this rule, control exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

**51.4(5)** A long-term acute care hospital located within a general hospital may contract with the host general hospital for the provision of services, including but not limited to pharmaceutical, radiological, laboratory, food and dietetic, surgical, anesthesia, emergency, housekeeping, laundry and environmental, or other services necessary to maintain a clean and safe physical environment. The contract shall be executed by the governing boards of the long-term acute care hospital and the host general hospital. All contracts shall clearly delineate the responsibilities of and services provided by the long-term acute care hospital and the host general hospital.

**51.4(6)** Any life safety code violation identified by the state fire marshal during an inspection of a licensee may be a life safety code violation for both the long-term acute care hospital and the general hospital.

**481—51.5(135B) Medical staff.**

**51.5(1)** A roster of medical staff members shall be kept.

**51.5(2)** All hospitals shall have one or more licensed physicians designated for emergency call service at all times.

**51.5(3)** A hospital shall not deny clinical privileges to physicians and surgeons, podiatrists, osteopaths or osteopathic surgeons, dentists, certified health service providers in psychology, physician assistants, advanced registered nurse practitioners or pharmacists licensed under Iowa Code chapter 147, 148, 148C, 149, 152, 153, or 155 or section 154B.7 solely by reason of the license held by the practitioner or solely by reasons of the school or institution in which the practitioner received health care education or postgraduate training if the health care education or postgraduate training was accredited by an organization recognized by the council on postsecondary accreditation or an accrediting group recognized by the United States Department of Education.

**51.5(4)** A hospital shall establish and implement written criteria for the granting of clinical privileges. The written criteria shall include, but not be limited to, consideration of the:

*a.* Ability of the applicant to provide patient care services independently or appropriately in the hospital;

*b.* License held by the applicant to practice;

*c.* Training, experience, and competence of applicant;

*d.* Relationship between the applicant's request for privileges and the hospital's current scope of patient care services;

*e.* Applicant's ability to provide comprehensive, appropriate and cost-effective services.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.6(135B) Patient rights and responsibilities.** The hospital governing board shall adopt a statement of principles relating to patient rights and responsibilities. In developing a statement of principles, the hospital may use reference statements of patient rights and responsibilities developed by the American Hospital Association, The Joint Commission (TJC), the American Osteopathic Association (AOA), DNV GL – Healthcare (DNV GL), the Center for Improvement in Healthcare Quality (CIHQ), and other appropriate sources.

**51.6(1)** The statement of principles shall be made available to patients of the hospital.

**51.6(2)** The statement of principles regarding patient rights shall, at a minimum, address:

*a.* Access to treatment regardless of age, race, creed, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, diagnosis, or source of payment for care;

*b.* Preservation of individual dignity and protection of personal privacy in receipt of care;

*c.* Confidentiality of medical and other appropriate information;

*d.* Assurance of reasonable safety within the hospital;

*e.* Knowledge of the identity of the physician or other practitioner primarily responsible for the patient's care as well as identity and professional status of others providing services to the patient while in the hospital;

*f.* Nature of patient's right to information regarding the patient's medical condition unless medically contraindicated, to consult with a specialist at the patient's request and expense, and to refuse treatment to the extent authorized by law;

*g.* Access to and explanation of patient billings; and

*h.* Process for patient pursuit of grievances.

**51.6(3)** The statement of principles regarding patient responsibilities shall, at a minimum, address:

*a.* Need of patient to provide accurate and complete information regarding the patient's health status;

- b. Need of patient to follow recommended treatment plans;
- c. Requirement that patient abide by hospital rules and regulations affecting patient care and conduct and be considerate of the rights of other patients and hospital personnel; and
- d. Obligation to fulfill the patient's financial obligations as soon as possible following discharge.

This rule is intended to implement Iowa Code chapter 135B.

[ARC 9253B, IAB 12/1/10, effective 1/5/11; ARC 1305C, IAB 2/5/14, effective 3/12/14; ARC 2472C, IAB 3/30/16, effective 5/4/16]

#### **481—51.7(135B) Abuse.**

##### **51.7(1) Definitions.**

"Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain or mental anguish. Neglect is a form of abuse and is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

"Child abuse" means the same as provided for in Iowa Code section 232.68.

"Dependent adult abuse" means the same as provided for in Iowa Code section 235E.1.

"Domestic abuse," as defined in Iowa Code section 236.2, means the commission of assault under any of the following circumstances:

1. The assault is between family or household members who resided together at the time of the assault;
2. The assault is between separated spouses or persons divorced from each other and not residing together at the time of the assault;
3. The assault is between persons who are parents of the same minor child, regardless of whether they have been married or have lived together at any time; or
4. The assault is between persons who have been family or household members residing together within the past year and are not residing together at the time of the assault.

"Elder abuse" means the same as provided for in Iowa Code section 235F.1.

"Family or household members," as defined in Iowa Code section 236.2, are spouses, persons cohabiting, parents, or other persons related by consanguinity or affinity, except children under the age of 18.

**51.7(2) Abuse prohibited.** Each patient shall receive kind and considerate care at all times and shall be free from all forms of abuse or harassment.

a. Restraints shall be applied only when they are necessary to prevent injury to the patient or to others and shall be used only when alternative measures are not sufficient to accomplish their purposes.

b. There must be a written order signed by the attending physician approving the use of restraints either at the time they are applied or as soon thereafter as possible.

c. Careful consideration shall be given to the methods by which the restraints can be speedily removed in case of fire or other emergency.

**51.7(3) Hospital response to domestic abuse.** Each hospital shall establish and implement protocols with respect to victims of domestic abuse.

a. The policies and procedures shall at a minimum provide for:

- (1) An interview with the victim in a place that ensures privacy;
- (2) Confidentiality of the person's treatment and information;
- (3) Sharing of information regarding the domestic abuse hotline and programs; and
- (4) Education of appropriate emergency department staff to assist in the identification of victims of domestic abuse.

b. The treatment records of victims of domestic abuse shall include:

- (1) An assessment of the extent of abuse to the victim specifically describing the location and extent of the injury and reported pain;
- (2) Evidence that the victim was informed of the telephone numbers for the domestic abuse hotline and domestic abuse programs, and the victim's response;
- (3) A record of the treatment and intervention by health care provider personnel;

(4) A record of the need for follow-up care and specification of the follow-up care to be given (e.g., X-rays, surgery, consultation, similar care); and

(5) The victim's statement of how the injury occurred.

**51.7(4) Hospital response to elder abuse.** Each hospital shall establish and implement protocols with respect to victims of elder abuse.

*a.* The policies and procedures shall at a minimum provide for:

(1) An interview with the victim in a place that ensures privacy;

(2) Confidentiality of the person's treatment and information; and

(3) Education of appropriate emergency department staff to assist in the identification of victims of elder abuse.

*b.* The treatment records of victims of elder abuse shall include:

(1) An assessment of the extent of abuse to the victim specifically describing the location and extent of the injury and reported pain;

(2) A record of the treatment and intervention by health care provider personnel;

(3) A record of the need for follow-up care and specification of the follow-up care to be given (e.g., X-rays, surgery, consultation, similar care); and

(4) The victim's statement of how the injury occurred.

**51.7(5) Mandatory reporting of child abuse and dependent adult abuse.** Each hospital shall ensure that written policies and procedures cover all requirements for the mandatory reporting of abuse pursuant to the Iowa Code. Each hospital shall provide that the treatment records of victims of child abuse or dependent adult abuse include a statement that the department of human services' protective services was contacted.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.8(135B) Organ, tissue and eye procurement.** Each hospital licensed in accordance with Iowa Code chapter 135B shall have in place written policies and protocols for organ, tissue and eye donation. Hospitals shall be familiar with the revised uniform anatomical gift Act, Iowa Code chapter 142C, and shall develop policies and protocols for consent to organ, tissue and eye donation by either the patient or an appropriate person to consent on the patient's behalf consistent with that Act's provisions. Hospitals shall ensure that the specific organ, tissue and eye procurement requirements are met, as provided in 42 CFR 482.45 or 42 CFR 485.643.

This rule is intended to implement Iowa Code section 135B.7.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.9(135B) Nursing services.**

**51.9(1)** The hospital shall have an organized nursing service which shall provide complete and efficient nursing care to each patient. The authority, responsibility and function of each nurse shall be clearly defined.

**51.9(2)** Registered nurses shall utilize the nursing process in the practice of nursing, consistent with accepted and prevailing practice. The nursing process is ongoing and includes:

*a.* Nursing assessments about the health status of an individual or group.

*b.* Formulation of a nursing diagnosis based on analysis of the data from the nursing assessment.

*c.* Planning of nursing care, which includes determining goals and priorities for actions that are based on the nursing diagnosis.

*d.* Nursing interventions implementing the plan of care.

*e.* Evaluation of the individual's or group's status in relation to established goals and the plan of care.

**51.9(3)** Licensed practical nurse(s) shall participate in the nursing process as described in subrule 51.9(2) consistent with accepted practice by assisting the registered nurse or physician.

**51.9(4)** All nurses employed in a hospital who practice nursing as a registered nurse or licensed practical nurse shall hold an active Iowa license or hold an active license in another state and be recognized for licensure in this state pursuant to the nurse licensure compact in Iowa Code section 152E.1.

**51.9(5)** There shall be a director of nursing service with administrative and executive competency who shall hold an active Iowa license or hold an active license in another state and be recognized for licensure in this state pursuant to the nurse licensure compact in Iowa Code section 152E.1.

**51.9(6)** Nursing management shall have had preparation courses and experience in accordance with hospital policy commensurate with the responsibility of the specific assignment.

**51.9(7)** All unlicensed personnel performing patient-care service shall be under the supervision of a registered nurse. The duties of unlicensed personnel shall be defined in writing by the hospital, and unlicensed personnel shall be instructed in all duties assigned to them.

**51.9(8)** The nursing service shall have adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care essential for the proper treatment, well-being, and recovery of the patient.

**51.9(9)** Written policies and procedures shall be established for the administrative and technical guidance of the personnel in the hospital. Each employee shall be familiar with these policies and procedures.

**51.9(10)** Each hospital shall have a minimum of one registered nurse on duty at all times.  
[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.10(135B) Water supply.** Rescinded IAB 12/22/93, effective 1/26/94.

**481—51.11(135B) Sewage disposal.** Rescinded IAB 12/22/93, effective 1/26/94.

**481—51.12(135B) Records and reports.**

**51.12(1) Medical records.** Accurate and complete medical records shall be maintained for all patients and signed by the appropriate provider. These records shall be filed and stored in an accessible manner and in accordance with the statute of limitations as specified in Iowa Code chapter 614.

**51.12(2) Hospital records.**

- a. *Admission records.* A register of all admissions to the hospital shall be maintained.
- b. *Death records.* A record of all deaths in the hospital shall be kept, including all information required on a standard death certificate as specified in Iowa Code chapter 144.
- c. *Birth records.* A record of all births in the hospital shall be kept, including all information required on a standard birth certificate as specified in Iowa Code chapter 144.
- d. *Controlled substance records.* Controlled substance records shall be maintained in accordance with state and federal laws, rules and regulations.

**51.12(3) Electronic records.** In addition to the access provided in 481—subrule 50.10(2), an authorized representative of the department shall be provided unrestricted access to electronic records pertaining to the care provided to the patients of the hospital.

a. If access to an electronic record is requested by the authorized representative of the department, the hospital may provide a tutorial on how to use its particular electronic system or may designate an individual who will, when requested, access the system, respond to any questions or assist the authorized representative as needed in accessing electronic information in a timely fashion.

b. The hospital shall provide a terminal where the authorized representative may access records.

c. If the hospital is unable to provide direct print capability to the authorized representative, the hospital shall make available a printout of any record or part of a record on request in a time frame that does not intentionally prevent or interfere with the department's survey or investigation.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.13(135B) Sterilizing equipment.** Rescinded IAB 12/22/93, effective 1/26/94; see 481—51.50(135B).

**481—51.14(135B) Pharmaceutical service.**

**51.14(1) General requirements.** Hospital pharmaceutical services shall be licensed in accordance with Iowa board of pharmacy rules in 657—Chapters 7, 8, 9, 10, 11, 20, 21, 22 and 40.

**51.14(2) Medication administration.** All drugs and biologicals must be administered by, or under the supervision of, nursing or other trained personnel in accordance with hospital policies and procedures. The person assigned the responsibility of medication administration must complete the entire procedure by personally preparing the dose from a multiple-dose container or using a prepackaged unit dose, personally administering it to the patient, and observing the act of the medication being taken.

**51.14(3) Medication orders.** All verbal orders must be authenticated by signature or other secure electronic method by the prescribing practitioner within a period not to exceed 30 days following a patient's discharge.

When verbal or electronic mechanisms are used to transmit medication orders, they must be accepted only by personnel that are authorized to do so by hospital policies and procedures in a manner consistent with federal and state law.

**51.14(4) Standing orders.** Standing orders for drugs may be used for specified patients when authorized by the prescribing practitioner. These standing orders shall be in accordance with policies and procedures established by the appropriate committee within each hospital. At a minimum, the standing orders shall:

- a. Specify the clinical situations under which the drug is to be administered;
- b. Specify the types of medical conditions of the patients for whom the standing orders are intended;
- c. Be reviewed and revised by the medical staff and the hospital's nursing and pharmacy leadership on a regular basis as specified by hospital policies and procedures;
- d. Be specific as to the drug, dosage, route, and frequency of administration; and
- e. Be dated, authorized by signature or other secure electronic method by the prescribing practitioner within a period not to exceed 30 days following a patient's discharge, and included in the patient's medical record.

**51.14(5) Self-administration of medications.** Patients shall only be permitted to self-administer medications when specifically ordered by the prescribing practitioner and the prescribing practitioner has determined this practice is safe for the specific patient. The hospital shall develop policies and procedures regarding storage and documentation of the administration of drugs.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.15(135B) Orders other than medication.** All verbal orders must be authenticated by the ordering practitioner within a period not to exceed 30 days following a patient's discharge. When verbal or electronic mechanisms are used to transmit orders, the orders must be accepted only by personnel who are authorized to accept them by hospital policies and procedures in a manner consistent with federal and state law.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.16(135B) Radiological services.**

**51.16(1)** The hospital must maintain, or have available, radiological services to meet the needs of the patients.

**51.16(2)** All radiological services including diagnostic, fluoroscopy, mammography, therapeutic, and nuclear medicine furnished by the hospital or its agent shall be furnished in compliance with 641—Chapters 38 to 42.

**481—51.17(135B) Laundry.** Rescinded IAB 12/22/93, effective 1/26/94; see 481—51.50(135B).

**481—51.18(135B) Laboratory service.**

**51.18(1)** The hospital must maintain, or have available, adequate laboratory and pathology services and facilities to meet the needs of its patients. The medical staff shall determine which laboratory tests are necessary to be performed on site to meet the needs of the patients.

**51.18(2)** Emergency laboratory services must be available 24 hours a day.

**51.18(3)** The hospital must ensure that all laboratory services provided to its patients are performed in a laboratory certified and operating in accordance with the Code of Federal Regulations in 42 CFR Part 493.

[ARC 1751C, IAB 12/10/14, effective 1/14/15]

**481—51.19** Reserved.

**481—51.20(135B) Food and nutrition services.**

**51.20(1)** *Food and nutrition service definition.* “Food service” means providing safe, satisfying, and nutritionally adequate food for patients through the provision of appropriate staff, space, equipment, and supplies. “Nutrition service” means providing assessment and education to ensure that the nutritional needs of the patients are met.

**51.20(2)** *General requirements.*

*a.* All food shall be handled, prepared, served, and stored in compliance with the requirements of the Food Code adopted under provisions of Iowa Code section 137F.2.

*b.* The food service shall provide food of the quality and quantity to meet the patient’s needs in accordance with the qualified health practitioner’s orders and, to the extent medically possible, to meet the current Recommended Dietary Allowances, adopted by the Food and Nutrition Board of the National Research Council, National Academy of Sciences, and the following:

(1) Not less than three meals shall be served daily unless contraindicated.

(2) Not more than 14 hours shall elapse between the evening meal and breakfast of the following day.

(3) Nourishment between meals shall be available to all patients unless contraindicated by the qualified health care practitioner.

(4) Patient food preferences shall be respected as much as possible, and substitutes shall be offered through use of appropriate food groups.

(5) When food is provided by a contract food service, all applicable requirements set forth herein shall be met. The hospital shall maintain adequate space, equipment, and staple food supplies to provide patient food service in emergencies.

*c.* Policies and procedures shall be developed and maintained.

*d.* A current diet manual approved by the dietitian and the medical staff shall be used as the basis for diet orders and for planning therapeutic diets. The diet manual shall be reviewed, revised and updated at least every five years. Copies of the diet manual shall be readily available to all medical, nursing, and food service personnel.

*e.* Therapeutic diets shall be provided as ordered by the qualified health care practitioner, including a registered, licensed dietitian, and shall be planned, prepared, and served with supervision or consultation from the registered, licensed dietitian. Persons responsible for therapeutic diets shall have sufficient knowledge of food to make appropriate substitutions when necessary.

*f.* The patient’s likes, dislikes, food allergies, and other pertinent information shall be included with the patient’s diet information.

*g.* Menus.

(1) Menus for regular and therapeutic diets shall be nutritionally appropriate, meet the needs of patients, and be available.

(2) If meals served vary from the planned menu, the change shall be noted in writing as part of the available menu. A copy of the menu as served shall be kept on file for at least 30 days.

(3) Menus should be planned with consideration for cultural and religious background and food habits of patients.

(4) Standardized recipes with nutritional analysis adjusted to number of portions shall be maintained and used in food preparation.

*h.* Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. Food shall be served attractively at appropriate and safe temperatures and in a form to meet individual needs.

*i.* Nutritional care.

(1) Nutrition screening shall be conducted by qualified hospital staff to determine the patient's need for a comprehensive nutrition assessment by the licensed dietitian.

(2) Nutritional care shall be integrated in the patient care plan, as appropriate, based upon the patient's diagnosis and length of stay.

(3) The licensed dietitian shall record in the patient's medical record any observations and information pertinent to medical nutrition therapy.

(4) Pertinent dietary records shall be included in the patient's transfer discharge record to ensure continuity of nutritional care.

(5) Upon discharge, nutrition counseling and education shall be provided to the patient and family as ordered by the qualified health care practitioner, requested by the patient or deemed appropriate by the licensed dietitian.

*j.* In-service training, in accordance with hospital policies, shall be provided for all food and nutrition service personnel. A record of subject areas covered, date and duration of each session, and attendance lists shall be maintained. In-service records shall be kept for a minimum of one year.

*k.* On the nursing units, a separate patient food storage area shall be maintained that ensures proper temperature control.

**51.20(3) Food and nutrition service staff.**

*a.* A licensed dietitian shall be employed on a full-time, part-time or consulting basis. Part-time or consultant services shall be provided on the premises at appropriate times on a regularly scheduled basis. These services shall be of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the food and nutrition service, approval of all menus, and participation in the development or revision of departmental policies and procedures and in planning and conducting in-service education programs.

*b.* If a licensed dietitian is not employed full-time, then one must be employed on a part-time or consultation basis with an additional full-time person who has completed a 250-hour dietary manager course and who shall be employed to be responsible for the operation of the food service.

*c.* Sufficient food service personnel shall be employed, oriented, trained, and their working hours scheduled to provide for the nutritional needs of the patients and to maintain the food service areas. If food service employees are assigned duties in other service areas, those duties shall not interfere with the sanitation, safety, or time required for food service work assignments.

**51.20(4) Food service equipment and supplies.** Equipment necessary for preparation and maintenance of menus, records, and references shall be provided. At least one week's supply of staple foods and a reasonable supply of perishable foods shall be maintained on the premises. Supplies shall be appropriate to meet the requirements of the menu.

[ARC 9252B, IAB 12/1/10, effective 1/5/11; ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.21** Reserved.

**481—51.22(135B) Equipment for patient care.** Hospital equipment shall be selected, maintained and utilized in accordance with the manufacturer's specifications and the needs of the patients.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.23** Reserved.

**481—51.24(135B) Infection control.** There shall be proper policies and procedures for the prevention and control of communicable diseases. The hospital shall provide for compliance with the current rules for the control of communicable disease as provided by the Iowa department of public health and current Centers for Disease Control and Prevention (CDC) guidelines for isolation precautions.

**51.24(1) Segregation.** There shall be proper arrangement of areas, rooms and patients' beds to provide for the prevention of cross-infections and the control of communicable diseases.

*a.* There shall be proper procedures for the cleansing of rooms and surgeries, immediately following the care of a communicable case.

*b.* Segregation of communicable cases shall include policies for staff, providing for proper isolation technique in order to prevent cross-infection.

**51.24(2) Visitors.** The hospital shall establish proper policies and procedures for the control of visitors to all services in the hospital.

**51.24(3) Health assessments.** Health assessments for all contracted or employed personnel who provide direct services shall be required at the commencement of employment and thereafter at least every four years.

*a.* “Direct services” means services provided through person-to-person contact. “Direct services” excludes services provided by individuals such as building contractors, repair workers, or others who are in the hospital for a very limited purpose, who are not in the hospital on a regular basis, and who do not provide any treatment or services for the patients of the hospital.

*b.* The health assessment may be performed by the person’s primary care provider.

*c.* The health assessment shall include, at a minimum, vital signs and an assessment for infectious or communicable diseases.

*d.* Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59.

**51.24(4) Notification.** Prior to removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease.

This rule is intended to implement Iowa Code section 135B.7.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.25** Reserved.

**481—51.26(135B) Surgical services.** All hospitals providing surgical services shall be properly organized and equipped to provide for the safe and aseptic treatment of surgical patients.

**51.26(1)** Written policies and procedures shall be implemented governing surgical services that are consistent with the needs of the patient and the resources of the hospital.

*a.* Policies and procedures shall be developed in consultation with and the approval of the hospital’s medical staff. At a minimum, the policies and procedures shall provide for:

(1) Surgical services under the direction of a qualified doctor of medicine or osteopathy.

(2) Delineation of the privileges and qualifications of individuals authorized to provide surgical services as set forth in the hospital’s medical staff bylaws and in accordance with subrule 51.5(4). The surgical service must maintain a roster of these individuals specifying the surgical privileges of each. Surgical privileges shall be reviewed and updated at least once every two years.

(3) Immediate availability of at least one registered nurse for the operating room suites to respond to emergencies.

(4) The qualifications and job descriptions of nursing personnel, surgical technicians, and other support personnel and continuing education required.

(5) Appropriate staffing for surgical services including physician and anesthesia coverage and other support personnel.

(6) Availability of ancillary services for surgical patients including, but not limited to: blood banking, laboratory, radiology, and anesthesia.

(7) Infection control and disease prevention, including aseptic surveillance and practice, identification of infected and noninfected cases, sterilization and disinfection procedures, and ongoing monitoring of infections and infection rates.

(8) Housekeeping requirements.

(9) Safety practices.

(10) Ongoing quality assessment, performance improvement, and process improvement.

(11) Provisions for the pathological examination of tissue specimens either directly or through contractual arrangements.

(12) Appropriate preoperative teaching and discharge planning.

*b.* Hospitals may consider the most recent edition of the following publications in the development of policies and procedures: “Statement of Principles,” American College of Surgeons; and “Standards and Recommended Practices,” Association of Operating Room Nurses.

**51.26(2)** Policies and procedures may be adjusted as appropriate to reflect the provision of surgical services in inpatient, outpatient or one-day surgical settings.

**51.26(3)** There must be an appropriate history and physical workup documented and a properly executed consent form in the chart of each patient prior to surgery, except in the event of an emergency.

**51.26(4)** A full operative report must be written or dictated within 24 hours following surgery and signed by the individual conducting the surgery.

**51.26(5)** Equipment available in the operating room, recovery room, outpatient surgical areas, and for postsurgical care, must be consistent with the needs of the patient.

**51.26(6)** The surgical facilities shall be constructed in accordance with 481—51.50(135B).  
[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.27** Reserved.

**481—51.28(135B) Anesthesia services.**

**51.28(1)** There shall be written policies and procedures governing anesthesia services which are consistent with the needs and resources of the hospital.

*a.* Policies and procedures shall be developed in consultation with and with the approval of the hospital’s medical staff.

*b.* At a minimum, the policies and procedures shall provide:

(1) Anesthesia services shall be provided under the direction of a qualified doctor of medicine or osteopathy.

(2) Delineation of the qualifications of individuals authorized to administer anesthesia as set out in the hospital’s medical staff bylaws or medical staff rules and regulations.

(3) For preanesthesia evaluation, appraisal of a patient’s current condition, preparation of an intraoperative anesthesia record, and discharge criteria for patients.

(4) For equipment functioning and safety, including ensuring that a qualified medical doctor, osteopathic physician and surgeon or anesthetist checks, prior to the administration of anesthesia, the readiness, availability, cleanliness, and working condition of all equipment to be used in the administration of anesthetic agents.

(5) For minimizing electrical hazards in all anesthetizing areas.

(6) Quality assurance which shall at least include infection control procedures; integration of anesthesia services into various areas of the hospital; and ongoing monitoring, review, and evaluation of anesthesia services, processes, and procedures.

**51.28(2)** Policies and procedures may be adjusted as appropriate to reflect provision of anesthesia services in inpatient or outpatient settings.

This rule is intended to implement Iowa Code section 135B.7.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.29** Reserved.

**481—51.30(135B) Emergency services.**

**51.30(1)** All hospitals shall provide for emergency service which offers reasonable care within the medical capabilities of the facility in determining whether an emergency exists, renders care appropriate to the facility and at a minimum renders lifesaving first aid and makes appropriate referral to a facility that is capable of providing needed services.

**51.30(2)** The hospital shall have written policies and procedures specifying the scope and conduct of patient care to be provided in the emergency service. The policies shall:

*a.* Specify the mechanism for providing physician coverage at all times.

*b.* Provide for training required of all personnel providing patient care in the emergency service.

c. Require that a medical record be kept on every patient given treatment in the emergency service and establish the medical record documentation. The documentation should include, at a minimum, appropriate information regarding the medical screening provided, except where the person refuses, then notation of patient refusal; physician documentation of the presence or absence of an emergency medical condition or active labor; physician documentation of transfer or discharge, stating the basis for transfer or discharge; and where transfer occurs, identity of the facility of transfer, acceptance of the patient by the facility of transfer, and means of transfer of the patient.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.31** Reserved.

**481—51.32(135B) Obstetric and neonatal services.**

**51.32(1)** All hospitals providing obstetrical care shall be properly organized and equipped to provide accommodations for mothers and newborn infants. The supervision of the maternity area shall be under the direction of a qualified registered nurse.

**51.32(2)** Written policies and procedures shall be implemented governing obstetric and neonatal services that are consistent with the needs of the patient and resources of the hospital.

a. Policies and procedures shall be developed in consultation with and with the approval of the hospital's medical staff. At a minimum, the policies and procedures shall provide for:

(1) Obstetric and neonatal services under the direction of a qualified doctor of medicine or osteopathy.

(2) Delineation of the privileges and qualifications of individuals authorized to provide obstetrical/gynecological service as set out in the hospital's medical staff bylaws.

(3) The qualifications of nursing personnel and continuing education required.

(4) Adequate staffing for obstetrical and newborn services.

(5) Location and arrangement of obstetric and newborn services.

(6) Infection control and disease prevention.

(7) Ongoing quality assessment.

b. Hospitals may consider the most recent edition of the following publications in the development of policies and procedures: 641—Chapter 150, Iowa Regionalized System of Perinatal Health Care, Iowa Administrative Code, and Guidelines for Perinatal Care, American Academy of Pediatrics, American College of Obstetrics and Gynecology.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.33** Reserved.

**481—51.34(135B) Pediatric services.**

**51.34(1)** All hospitals providing pediatric care shall be properly organized and equipped to provide appropriate accommodations for children. The supervision of the pediatric area shall be under the direction of a qualified registered nurse.

**51.34(2)** Written policies and procedures shall be implemented governing pediatric services that are consistent with the needs of the child and resources of the hospital.

a. Policies and procedures shall be developed in consultation with and the approval of the hospital's medical staff. At a minimum, the policies and procedures shall provide for:

(1) Pediatric services under the medical direction of a qualified doctor of medicine or osteopathy.

(2) Delineation of the privileges and qualifications of individuals authorized to provide pediatric services as set out in the hospital's medical staff bylaws.

(3) The qualifications of nursing personnel and continuing education required, including care in the event of emergency situations.

(4) Adequate staffing and equipment for pediatric services including ancillary services. Staff participating in the care of pediatric patients shall have education appropriate for the care of pediatric patients.

(5) Ancillary services for pediatric patients shall be available and include, but not be limited to, pharmaceutical care, laboratory services, respiratory therapy, physical therapy and speech therapy.

(6) Ongoing quality assessment.

(7) Written protocol for transfer of pediatric patients in the event the hospital does not have capability to provide care for these patients.

*b.* Hospitals may consider the most recent editions of the following publications in the development of policies and procedures: the American Academy of Pediatrics' Policy Reference Guide and policy statements which are published on a monthly basis in "Pediatrics" and the "Pediatric & Neonatal Dosage Handbook," American Pharmacists Association.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.35** Reserved.

**481—51.36(135B) Psychiatric services.**

**51.36(1)** Any hospital operating as a psychiatric hospital or operating a psychiatric unit shall:

*a.* Be a hospital or unit primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of persons with psychiatric illnesses/disorders;

*b.* Meet the general and specialized rules of this chapter pertaining to general hospitals. If medical and surgical diagnostic and treatment services are not available within the institution, the institution shall have an agreement with an outside source of these services to ensure they are immediately available;

*c.* Have policies and procedures for informing patients of their rights and responsibilities and for ensuring the availability of a patient advocate; and

*d.* Have sufficient numbers of qualified professionals and support staff to evaluate patients, formulate written individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning.

**51.36(2)** Personnel.

*a. Director of inpatient psychiatric services.* The director of inpatient psychiatric services shall be a doctor of medicine or osteopathy qualified to meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. The number and qualifications of doctors of medicine, doctors of osteopathy or advanced registered nurse practitioners certified in psychiatric or mental health nursing on staff must be adequate to provide essential psychiatric and medical services.

*b. Director of psychiatric nursing services.* The director of psychiatric nursing services shall:

(1) Be a registered nurse who has a master's degree in psychiatric or mental health nursing;

(2) Be an advanced registered nurse practitioner certified in psychiatric or mental health nursing;

or

(3) Be qualified by education and two years' experience in the care of persons with mental disorders.

*c. Psychological services.* Psychological services shall be provided or available which are in compliance with Iowa Code chapter 154B.

*d. Social services.* Social services shall provide, or have available by contract, at least one staff member who has:

(1) A master's degree from an accredited school of social work; or

(2) A bachelor's degree in social work with two years' experience in the care of persons with mental disorders.

*e. Therapeutic services.* Therapeutic activities shall be provided by qualified therapists. The activities shall be appropriate to the needs and interests of the patients.

**51.36(3)** Individual written plan of care. An individual written plan of care shall be developed by an interdisciplinary team of a physician and other personnel who are employed by, or who provide service under contract to patients in the facility. The plan of care shall:

- a. Be based on a diagnostic and psychiatric evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the patient. The initial diagnostic and psychiatric evaluation shall be completed within 60 hours of admission;
- b. Be developed by an interdisciplinary team in consultation with the patient, the patient's legal guardian, and others who are currently providing services or who will provide care upon discharge;
- c. State treatment objectives through measurable and obtainable outcomes;
- d. Prescribe an integrated program of therapies, activities, and experiences designed to meet those objectives;
- e. Include an appropriate postdischarge plan with coordination of services to provide continuity of care following discharge; and
- f. Be reviewed as needed by the interdisciplinary team for the continued appropriateness of the plan and for a determination of needed changes.

[ARC 2472C, IAB 3/30/16, effective 5/4/16]

**481—51.37** Reserved.

**481—51.38(135B) Long-term care service.**

**51.38(1) Long-term care service definition.** Long-term care service means any building or distinct part of a building utilized by the hospital for the provision of a service (except as provided by 51.38(2) below) that falls within the definition of a health care facility as specified in Iowa Code chapter 135C and Iowa Code section 135C.1(12), nursing facility, as it would be applied were it not operating as part of a hospital licensed under Iowa Code chapter 135B.

**51.38(2) Long-term care service general requirements.** The general requirements for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved. Exceptions to those rules requiring distinct parts to be established may be waived where it is found to be in the best interest of the long-term care resident and of no detriment to the patients in the hospital.

Requests for variances to other rules for which equivalent health, safety and welfare provisions are provided may be made in accordance with the appropriate health care facility rules. In any case where a distinct part has been established for long-term residents or where the department has given approval for the intermingling of such residents with acute care patients, the same provisions and rules promulgated under Iowa Code chapter 135C shall be applicable. These rules include, but are not limited to, the same restrictions, obligations, programs of care, personal and rehabilitative services and all of the conveniences and considerations which the residents would normally have received in a licensed health care facility.

**51.38(3) Long-term care service staff.** The staffing requirements for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved. Where a hospital operates a freestanding nursing care facility, it shall be under the administrative authority of a licensed nursing home administrator who will be responsible to the hospital's administrator. Where a hospital operates a distinct part long-term care unit under the auspices of the hospital license, a licensed nursing home administrator is not required.

**51.38(4) Long-term care service equipment and supplies.** The equipment and supplies required for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved.

**51.38(5) Long-term care service space.** The space requirements for the various areas and resident rooms of the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved.

**481—51.39(135B) Penalty and enforcement.** See Iowa Code sections 135B.14 to 135B.16.

**481—51.40(135B) Validity of rules.** Rescinded ARC 2472C, IAB 3/30/16, effective 5/4/16.

**481—51.41(135B) Criminal, dependent adult abuse, and child abuse record checks.**

**51.41(1) Definitions.** The following definitions apply for the purposes of this rule.

“*Background check*” or “*record check*” means criminal history, child abuse and dependent adult abuse record checks.

“*Comprehensive preliminary background check*” means a criminal history check of all states in which the applicant has worked or resided over the seven-year period immediately prior to submitting an application for employment that is conducted by an approved third-party vendor.

“*Direct services*” means services provided through person-to-person contact. “Direct services” excludes services provided by individuals such as building contractors, repair workers, or others who are in a hospital for a very limited purpose, who are not in the hospital on a regular basis, and who do not provide any treatment or services for the patients of the hospital.

“*Employee*” means any individual who is paid either by the hospital or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors) to provide direct or indirect services to patients of a hospital.

“*Evaluation*” means review by the department of human services to determine whether a founded child abuse, dependent adult abuse or criminal conviction warrants the person’s being prohibited from employment in a hospital.

“*Indirect services*” means services provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance.

**51.41(2) Requirements for employer prior to employing an individual.** Prior to employment of a person in a hospital, the hospital shall complete the background check requirements set forth below.

a. *Informing the prospective employee.* A hospital shall ask each person seeking employment by the hospital, “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other state?” The person shall also be informed that a background check will be conducted. The person shall indicate, by signature, that the person has been informed that the background check will be conducted.

b. *Conducting a background check.* The hospital shall either request that the department of public safety perform a criminal history check and that the department of human services perform child and dependent adult abuse record checks of the person in this state, or access the single contact repository (SING) to perform the required background check. If the SING is used, the hospital shall submit the person’s maiden name, if applicable, with the background check request.

c. *If a person considered for employment has been convicted of a crime.* If a person being considered for employment in a hospital has been convicted of a crime under a law of any state, the hospital shall request that the department of human services perform an evaluation to determine whether the crime warrants prohibition of the person’s employment in the hospital.

d. *If a person considered for employment has a record of founded child abuse or dependent adult abuse.* If a person being considered for employment in a hospital has a record of founded child or dependent adult abuse under a law of any state, the hospital shall request that the department of human services perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the hospital.

e. *Employment pending evaluation.* The hospital may provisionally employ a person prior to completion of the required record check and evaluation by the department of human services, as applicable, subject to all of the following:

(1) The hospital shall have accessed SING to perform the required record check and be awaiting results from SING or awaiting evaluation by the department of human services, as applicable;

(2) If applicable, the hospital shall request an evaluation by the department of human services in accordance with paragraph 51.41(2)“b” or “c” within 30 days of receipt of the SING record check results;

(3) The hospital shall have utilized an approved third-party vendor to perform a comprehensive preliminary background check;

(4) If the comprehensive preliminary background check determines that the person being considered for employment has been convicted of a crime, the crime does not constitute a felony as

defined in Iowa Code section 701.7 and is not a crime specified pursuant to Iowa Code chapter 708, 708A, 709, 709A, 710, 710A, 711, or 712 or pursuant to Iowa Code section 726.3, 726.7, or 726.8;

(5) The comprehensive preliminary background check shall have determined that the person being considered for employment does not have a record of founded child abuse or dependent adult abuse, or, if the person being considered for employment does have a record of founded child abuse or dependent adult abuse, subrule 51.41(6) is applicable; and

(6) The provisional employment may continue until such time as the required record check through SING and evaluation by the department of human services, as applicable, are completed.

*f. Validity of background check results.* The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the hospital.

**51.41(3) Employment prohibition.** Except as provided in paragraph 51.41(2)“e,” a person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a hospital unless an evaluation has been performed by the department of human services.

**51.41(4) Transfer of an employee to another hospital owned or operated by the same person.** If an employee transfers from one hospital to another hospital owned or operated by the same person, without a lapse in employment, the hospital is not required to request additional criminal and child and dependent adult abuse record checks of that employee.

**51.41(5) Transfer of ownership of a hospital.** If the ownership of a hospital is transferred, at the time of transfer the background check required by this rule shall be performed for each employee for whom there is no documentation that such background check has been performed. The hospital may continue to employ such employee pending the performance of the background check and any related evaluation.

**51.41(6) Change of employment—person with criminal or abuse record—exception to record check evaluation requirements.** A person with a criminal or abuse record who is or was employed by a certified hospital and is hired by another certified hospital shall be subject to the background check.

*a.* A reevaluation of the latest record check is not required, and the person may commence employment with the other hospital if the following requirements are met:

(1) The department of human services previously performed an evaluation concerning the person’s criminal or abuse record and concluded the record did not warrant prohibition of the person’s employment;

(2) The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the prior evaluation;

(3) 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;

(4) Any restrictions placed on the person’s employment in the previous evaluation by the department of human services and still applicable shall remain applicable in the person’s subsequent employment; and

(5) The person subject to the background check has maintained a copy of the previous evaluation and provided it 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 current record check evaluation shall be performed.

*b.* For purposes of this subrule, a position is “substantially the same or has the same job responsibilities” if the position requires the same certification, licensure, or advanced training. For example, a licensed nurse has substantially the same or the same job responsibilities as a director of nursing; a certified nurse aide does not have substantially the same or the same job responsibilities as a licensed nurse.

*c.* The subsequent employer must maintain the previous evaluation in the employee’s personnel file for verification of the exception to the requirement for a record check evaluation.

*d.* The subsequent employer may request a reevaluation of the background check and may employ the person while the reevaluation is being performed, even though an exemption under paragraph 51.41(6)“a” may be authorized.

**51.41(7)** *Employee notification of criminal convictions or founded abuse after employment.* If a person employed by an employer that is subject to this rule is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the employer of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

*a.* The employer shall act to verify the information within seven calendar days of notification. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

*b.* If the information is verified, the hospital shall follow the requirements of paragraphs 51.41(2) "c" and "d."

*c.* The employer may continue to employ the person pending the performance of an evaluation by the department of human services.

*d.* A person who is required by this subrule to inform the person's employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

*e.* The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under this subrule.

**51.41(8)** *Hospital receipt of credible information that an employee has been convicted of a crime or founded for abuse.* If the hospital receives credible information, as determined by the hospital, from someone other than the employee, that the employee has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment, and the employee has not informed the employer of the information within the time required by subrule 51.41(7), the hospital shall take the following actions:

*a.* The hospital shall act to verify credible information within seven calendar days of receipt. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

*b.* If the information is verified, the hospital shall follow the requirements of paragraphs 51.41(2) "c" and "d."

**51.41(9)** *Proof of background checks for temporary employment agencies and contractors.* Proof of background checks may be kept in the files maintained by temporary employment agencies and contractors. Facilities may require temporary employment agencies and contractors to provide a copy of the result of the background checks. Copies of such results shall be made available to the department upon request.

This rule is intended to implement Iowa Code sections 135B.7 and 135B.34 and 2020 Iowa Acts, Senate File 2299.

[ARC 0963C, IAB 8/21/13, effective 9/25/13; ARC 1304C, IAB 2/5/14, effective 3/12/14; ARC 1751C, IAB 12/10/14, effective 1/14/15; ARC 2472C, IAB 3/30/16, effective 5/4/16; ARC 5421C, IAB 2/10/21, effective 3/17/21]

**481—51.42 to 51.49** Reserved.

**481—51.50(135B) Minimum standards for construction.**

**51.50(1)** *Minimum standards.* Hospitals and off-site premises licensed under this chapter shall be built in accordance with the following construction standards.

*a.* Construction shall be in accordance with the standards set forth in the Guidelines for Design and Construction of Hospitals, 2018 edition, published by the Facility Guidelines Institute.

b. Existing hospitals and off-site premises built in compliance with prior editions of the hospital construction guidelines will be deemed in compliance with subsequent regulations, with the exception of any new structural renovations, additions, functional alterations, or changes in utilization to existing facilities, which shall meet the standards specified in this subrule.

c. The design and construction of a hospital or off-site premises shall be in conformance with the provisions of 661—Chapter 205.

d. In jurisdictions without a local building code enforcement program, the construction shall be in conformance with the state building code, as authorized by Iowa Code section 103A.7, in effect at the time of plan submittal for review and approval. In jurisdictions with a local building code enforcement program, local building code enforcement must include both the adoption and enforcement of a local building code through plan reviews and inspections.

e. In any case in which an applicable requirement of 661—Chapter 205 is inconsistent with an applicable requirement of the state building code, the hospital or off-site premises shall be deemed to be in compliance with the state building code requirement if the requirement of 661—Chapter 205 is met.

**51.50(2) *Submission of construction documents.***

a. Submissions of architectural technical documents, engineering documents, and plans and specifications to the building code commissioner are the responsibility of the owner of the building or facility, although the actual submission may be completed by an authorized agent of the owner or the responsible design professional.

b. Submissions shall comply with the provisions of rule 661—300.4(103A).

c. The responsible design professional shall certify that the building plans meet the requirements specified in subrule 51.50(1), unless a variance has been granted pursuant to subrule 51.50(3).

**51.50(3) *Variations.*** The director of the department may grant variances to building and construction guidelines as contained in the Guidelines for Design and Construction of Hospitals, 2018 edition. The hospital or off-site premises must submit a variance request in writing to the director. The request must demonstrate how patient safety and the quality of care offered will not be compromised by the variance. The facility must demonstrate its ability to completely fulfill all other requirements of the service. The director shall make a written determination of the request. In determining whether a variance request shall be granted, the director shall give consideration to the following conditions and to any other conditions the director deems relevant:

a. The design and planning for the specific property shall offer improved or compensating features which provide equivalent desirability and utility;

b. Alternate or special construction methods, techniques, and mechanical equipment shall offer equivalent durability; utility; safety; structural strength and rigidity; sanitation; odor control; protection from corrosion, decay and insect attack; and quality of workmanship;

c. The health, safety or welfare of any patient shall not be endangered;

d. The variance shall be limited to the specific project under consideration and shall not be construed as establishing a precedent for similar acceptance in other cases;

e. Occupancy and function of the building shall be considered; and

f. The type of licensing shall be considered.

[ARC 9251B, IAB 12/1/10, effective 1/5/11; ARC 0135C, IAB 5/30/12, effective 7/4/12; ARC 2157C, IAB 9/30/15, effective 11/4/15; ARC 4070C, IAB 10/10/18, effective 11/14/18]

**481—51.51(135B) Minimum standards for construction after July 8, 1998, and prior to May 22, 2002.** Rescinded IAB 12/1/10, effective 1/5/11.

**481—51.52(135B) Minimum standards for construction after May 22, 2002.** Rescinded IAB 12/1/10, effective 1/5/11.

**481—51.53(135B) Critical access hospitals.** Critical access hospitals shall meet the following criteria:

**51.53(1)** The hospital shall be no less than 35 miles from another hospital or no less than 15 miles over secondary roads or shall be designated by the department of public health as a necessary provider of health care prior to January 1, 2006.

**51.53(2)** The hospital shall be a public or nonprofit hospital and shall be located in a county in a rural area. Rural counties do not include Black Hawk, Johnson, Linn, Polk, Pottawattamie, Scott and Woodbury Counties. All other counties are considered to be in rural areas for purposes of this subrule.

**51.53(3)** The hospital shall provide 24-hour emergency care services as described in 481 IAC 51.30(135B).

**51.53(4)** The hospital shall maintain no more than 25 acute care inpatient beds. However, if the hospital provides inpatient psychiatric services in a distinct part unit or inpatient rehabilitation services in a distinct part unit, no more than 10 beds shall be maintained in the distinct part unit. The beds in the distinct part unit are excluded from the 25 inpatient-bed count limit specified in 42 CFR 485.620(a).

**51.53(5)** The hospital shall meet the Medicare conditions of participation as a critical access hospital as described in 42 CFR Part 485, Subpart F.

**51.53(6)** The hospital shall continue to comply with all general hospital license requirements as defined in 481 IAC 51.

**51.53(7)** The department shall recognize, in lieu of its own inspection, the comparable inspections and inspections findings of The Joint Commission (TJC), the American Osteopathic Association (AOA), DNV GL – Healthcare (DNV GL), or the Center for Improvement in Healthcare Quality (CIHQ) if the department is provided with copies of all requested materials relating to the inspections and the inspection process.

[ARC 9253B, IAB 12/1/10, effective 1/5/11; ARC 1305C, IAB 2/5/14, effective 3/12/14; ARC 2472C, IAB 3/30/16, effective 5/4/16]

These rules are intended to implement Iowa Code chapter 135B.

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<sup>◊</sup> Two or more ARCs

<sup>1</sup> Hospital Protocol for Donor Requests as it appeared in IAC 641—Chapter 180 prior to 4/4/90.

<sup>2</sup> January 16, 2013, effective date of 51.24(3) [ARC 0484C] delayed 70 days by the Administrative Rules Review Committee at its meeting held January 8, 2013.



CHAPTER 58  
NURSING FACILITIES

[Prior to 7/15/87, Health Department[470] Ch 58]

**481—58.1(135C) Definitions.** For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words “shall” and “must” indicates those standards are mandatory. The use of the words “should” and “could” indicates those standards are recommended.

“*Accommodation*” means the provision of lodging, including sleeping, dining, and living areas.

“*Administrator*” means a person licensed pursuant to Iowa Code chapter 147 who administers, manages, supervises, and is in general administrative charge of a nursing facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

“*Ambulatory*” means the condition of a person who immediately and without aid of another is physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“*Basement*” means that part of a building where the finish floor is more than 30 inches below the finish grade.

“*Board*” means the regular provision of meals.

“*Chairfast*” means capable of maintaining a sitting position but lacking the capacity of bearing own weight, even with the aid of a mechanical device or another individual.

“*Communicable disease*” means a disease caused by the presence of viruses or microbial agents within a person’s body, which agents may be transmitted either directly or indirectly to other persons.

“*Department*” means the state department of inspections and appeals.

“*Distinct part*” means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

“*Medication*” means any drug including over-the-counter substances ordered and administered under the direction of the physician.

“*Nonambulatory*” means the condition of a person who immediately and without aid of another is not physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“*Nourishing snack*” is defined as a verbal offering of items, single or in combination, from the basic food groups. Adequacy of the “nourishing snack” will be determined both by resident interviews and by evaluation of the overall nutritional status of residents in the facility.

“*Person directed care environment*” means the provision of care and services provided in a facility that promotes decision making and choices by the resident, enhances the primary caregiver’s capacity to respond to each resident’s needs, and promotes a homelike environment. Examples of a person directed care environment include, but are not limited to, the Green House concept, the Eden alternative, service houses and neighborhoods.

“*Personal care*” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are assistance in getting in and out of bed, assistance with personal hygiene and bathing, assistance with dressing, meal assistance, and supervision over medications which can be self-administered.

“*Potentially hazardous food*” means a food that is natural or synthetic and that requires temperature control because it is in a form capable of supporting the rapid and progressive growth of infectious or toxigenic microorganisms, the growth and toxin production of clostridium botulinum, or in raw shell eggs, the growth of salmonella enteritidis. Potentially hazardous food includes an animal food (a food of animal origin) that is raw or heat-treated; a food of plant origin that is heat-treated or consists of raw seed sprouts; cut melons; and garlic and oil mixtures that are not acidified or otherwise modified at a food processing plant in a way that results in mixtures that do not support growth of bacteria.

“*Primary care provider*” means any of the following who provide primary care and meet certification standards:

1. A physician who is a family or general practitioner or an internist.
2. An advanced registered nurse practitioner.
3. A physician assistant.

*“Program of care”* means all services being provided for a resident in a health care facility.

*“Qualified intellectual disabilities professional”* means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with persons with an intellectual disability.

*“Qualified nurse”* means a registered nurse or a licensed practical nurse, as defined in Iowa Code chapter 152.

*“Rate”* means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules and regulations.

*“Responsible party”* means the person who signs or cosigns the admission agreement required in 481—58.13(135C) or the resident’s guardian or conservator if one has been appointed. In the event that a resident does not have a guardian, conservator or other person signing the admission agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

*“Restraints”* means any chemical, manual method or physical or mechanical device, material, or equipment attached to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

*“Substantial evening meal”* is defined as an offering of three or more menu items at one time, one of which includes a high protein such as meat, fish, eggs or cheese. The meal would represent no less than 20 percent of the day’s total nutritional requirements.

[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 1752C, IAB 12/10/14, effective 1/14/15]

**481—58.2(135C) Variances.** Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual nursing facility. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

**58.2(1)** To request a variance, the licensee must:

- a. Apply for variance in writing on a form provided by the department;
- b. Cite the rule or rules from which a variance is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangements or compensating circumstances which justify the variance;
- e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

**58.2(2)** Upon receipt of a request for variance, the director of inspections and appeals will:

- a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

**58.2(3)** Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

**481—58.3(135C) Application for licensure.**

**58.3(1)** Initial application and licensing. In order to obtain an initial nursing facility license, for a nursing facility which is currently licensed, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Applicable exceptions found in rule 481—61.2(135C) shall apply based on the construction date of the facility.

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the nursing facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door location;

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Meet the requirements of a nursing facility for which licensure application is made;

h. Comply with all other local statutes and ordinances in existence at the time of licensure;

i. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**58.3(2)** In order to obtain an initial nursing facility license for a facility not currently licensed as a nursing facility, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Exceptions noted in 481—subrule 61.1(2) shall not apply;

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the nursing facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door locations;

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Comply with all other local statutes and ordinances in existence at the time of licensure;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**58.3(3) *Renewal application.*** In order to obtain a renewal of the nursing facility license, the applicant must:

a. Submit the completed application form 30 days prior to annual license renewal date of nursing facility license;

b. Submit the statutory license fee for a nursing facility with the application for renewal;

c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;

d. Submit appropriate changes in the résumé to reflect any changes in the resident care program or other services.

**58.3(4)** Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

#### **481—58.4(135C) General requirements.**

**58.4(1)** The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

**58.4(2)** The license shall be valid only in the possession of the licensee to whom it is issued.

**58.4(3)** The posted license shall accurately reflect the current status of the nursing facility. (III)

**58.4(4)** Licenses expire one year after the date of issuance or as indicated on the license.

**58.4(5)** No nursing facility shall be licensed for more beds than have been approved by the health facilities construction review committee.

**58.4(6)** Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

**481—58.5(135C) Notifications required by the department.** The department shall be notified:

**58.5(1)** Within 48 hours, by letter, of any reduction or loss of nursing or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

**58.5(2)** Of any proposed change in the nursing facility's functional operation or addition or deletion of required services; (III)

**58.5(3)** Thirty days before addition, alteration, or new construction is begun in the nursing facility or on the premises; (III)

**58.5(4)** Thirty days in advance of closure of the nursing facility; (III)

**58.5(5)** Within two weeks of any change in administrator; (III)

**58.5(6)** When any change in the category of license is sought; (III)

**58.5(7)** Prior to the purchase, transfer, assignment, or lease of a nursing facility, the licensee shall:

- a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)
- b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)
- c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's nursing facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

**58.5(8)** Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a nursing facility, the department shall upon request send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

**481—58.6(135C) Witness fees.** Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

**481—58.7(135C) Licenses for distinct parts.**

**58.7(1)** Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

**58.7(2)** The following requirements shall be met for a separate licensing of a distinct part:

- a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)
- b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;
- c. A distinct part must be operationally and financially feasible;
- d. A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)
- e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

**481—58.8(135C) Administrator.**

**58.8(1)** Each nursing facility shall have one person in charge, duly licensed as a nursing home administrator or acting in a provisional capacity. (III)

**58.8(2)** A licensed administrator may act as an administrator for not more than two nursing facilities.

- a. The distance between the two facilities shall be no greater than 50 miles. (II)
- b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)
- c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

**58.8(3)** The licensee may be the licensed nursing home administrator providing the licensee meets the requirements as set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

**58.8(4)** A provisional administrator may be appointed on a temporary basis by the nursing facility licensee to assume the administrative duties when the facility, through no fault of its own, has lost its administrator and has been unable to replace the administrator.

- a. No facility licensed under Iowa Code chapter 135C shall be permitted to have a provisional administrator for more than 12 consecutive months.
- b. The facility shall notify the department in writing within ten business days of the administrator's appointment. The written notice shall include the estimated time frame for the appointment of the provisional administrator and the reason for the appointment of a provisional administrator. (III)
- c. The provisional administrator's appointment must be approved by the board of examiners for nursing home administrators. The approval shall be confirmed in writing to the department. (III)

**58.8(5)** In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. The administrator shall not be absent from the facility for more than 3 months without approval of the department. (III)

The person designated shall:

- a. Be knowledgeable of the operation of the facility; (III)
- b. Have access to records concerned with the operation of the facility; (III)
- c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)
- d. Be at least 21 years of age; (III)
- e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)
- f. Have had training to carry out assignments and take care of emergencies and sudden illness of residents. (III)

**58.8(6)** A licensed administrator in charge of two facilities shall employ an individual designated as a full-time assistant administrator for each facility. (III)

**58.8(7)** An administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. (III)

[ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 2020C, IAB 6/10/15, effective 7/15/15]

#### **481—58.9(135C) Administration.**

**58.9(1)** The licensee shall:

- a. Assume the responsibility for the overall operation of the nursing facility; (III)
- b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)
- c. Establish written policies, which shall be available for review, for the operation of the nursing facility. (III)

**58.9(2)** The administrator shall:

- a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)
- b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)
- c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)
- d. Make available the nursing facility payroll records for departmental review as needed; (III)

e. Be required to maintain a staffing pattern of all departments. These records must be maintained for six months and are to be made available for departmental review. (III)

**481—58.10(135C) General policies.**

**58.10(1)** There shall be written personnel policies in facilities of more than 15 beds to include hours of work, and attendance at educational programs. (III)

**58.10(2)** There shall be a written job description developed for each category of worker. The job description shall include title of job, job summary, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

**58.10(3)** There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a. Employees shall have a physical examination before employment. (I, II, III)
- b. Employees shall have a physical examination at least every four years. (I, II, III)
- c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

**58.10(4)** Health certificates for all employees shall be available for review. (III)

**58.10(5)** Rescinded IAB 10/19/88, effective 11/23/88.

**58.10(6)** There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency. (III)

**58.10(7)** The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

**58.10(8)** Infection control program. Each facility shall have a written and implemented infection control and exposure control program with policies and procedures based on the guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. (I, II, III) CDC guidelines are available at [www.cdc.gov/ncidod/dhqp/index.html](http://www.cdc.gov/ncidod/dhqp/index.html).

**58.10(9)** Infection control committee. Each facility shall establish an infection control committee of representative professional staff responsible for overall infection control in the facility. (III)

a. The committee shall annually review and revise the infection control policies and procedures to monitor effectiveness and suggest improvement. (III)

b. The committee shall meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions. (III)

c. The committee shall monitor the health aspect and the environment of the facility. (III)

**58.10(10)** There shall be written policies for resident care programs and services as outlined in these rules. (III)

**58.10(11)** Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

[ARC 0663C, IAB 4/3/13, effective 5/8/13]

**481—58.11(135C) Personnel.**

**58.11(1) General qualifications.**

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a nursing facility. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a nursing facility. (II)

c. No person shall be allowed to provide services in a facility if the person has a disease:

- (1) Which is transmissible through required workplace contact, (I, II, III)
- (2) Which presents a significant risk of infecting others, (I, II, III)
- (3) Which presents a substantial possibility of harming others, and (I, II, III)
- (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

*d.* Reserved.

*e.* Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

*f.* Persons employed in all departments, except the nursing department of a nursing facility shall be qualified through formal training or through prior experience to perform the type of work for which they have been employed. Prior experience means at least 240 hours of full-time employment in a field related to their duties. Persons may be hired in laundry, housekeeping, activities and dietary without experience or training if the facility institutes a formal in-service training program to fit the job description in question and documents such as having taken place within 30 days after the initial hiring of such untrained employees. (III)

*g.* Rescinded, effective 7/14/82.

*h.* The health services supervisor shall be a qualified nurse as defined in these regulations. (II)

*i.* Those persons employed as nurse's aides, orderlies, or attendants in a nursing facility who have not completed the state-approved 75-hour nurse's aide program shall be required to participate in a structured on-the-job training program of 20 hours' duration to be conducted prior to any resident contact, except that contact required by the training program. This educational program shall be in addition to facility orientation. Each individual shall demonstrate competencies covered by the curriculum. This shall be observed and documented by an R.N. and maintained in the personnel file. No aide shall work independently until this is accomplished, nor shall the aide's hours count toward meeting the minimum hours of nursing care required by the department. The curriculum shall be approved by the department. An aide who has completed the state-approved 75-hour course may model skills to be learned.

Further, such personnel shall be enrolled in a state-approved 75-hour nurse's aide program to be completed no later than six months from the date of employment. If the state-approved 75-hour program has been completed prior to employment, the on-the-job training program requirement is waived. The 20-hour course is in addition to the 75-hour course and is not a substitute in whole or in part. The 75-hour program, approved by the department, may be provided by the facility or academic institution.

Newly hired aides who have completed the state-approved 75-hour course shall demonstrate competencies taught in the 20-hour course upon hire. This shall be observed and documented by an R.N. and maintained in the personnel file.

All personnel administering medications must have completed the state-approved training program in medication administration. (II)

*j.* There shall be an organized ongoing in-service educational and training program planned in advance for all personnel in all departments. (II, III)

*k.* Nurse aides, orderlies or attendants in a nursing facility who have received training other than the Iowa state-approved program, must pass a challenge examination approved by the department of inspections and appeals. Evidence of prior formal training in a nursing aide, orderly, attendant, or other comparable program must be presented to the facility or institution conducting the challenge examination before the examination is given. The approved facility or institution, following department of inspections and appeals guidelines, shall make the determination of who is qualified to take the examination. Documentation of the challenge examinations administered shall be maintained.

**58.11(2) *Nursing supervision and staffing.***

*a.* Rescinded IAB 8/7/91, effective 7/19/91.

*b.* Where only part-time nurses are employed, one nurse shall be designated health service supervisor. (III)

*c.* A qualified nurse shall be employed to relieve the supervising nurses, including charge nurses, on holidays, vacation, sick leave, days off, absences or emergencies. Pertinent information for contacting such relief person shall be posted at the nurse's station. (III)

*d.* When the health service supervisor serves as the administrator of a facility 50 beds and over, a qualified nurse must be employed to relieve the health service supervisor of nursing responsibilities. (III)

*e.* The department may establish on an individual facility basis the numbers and qualifications of the staff required in the facility using as its criteria the services being offered and the needs of the residents. (III)

*f.* Additional staffing, above the minimum ratio, may be required by the department commensurate with the needs of the individual residents. (III)

*g.* The minimum hours of resident care personnel required for residents needing intermediate nursing care shall be 2.0 hours per resident day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. If the maximum medical assistance rate is reduced below the 74th percentile, the requirement will return to 1.7 hours per resident per day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. (II, III)

*h.* The health service supervisor's hours worked per week shall be included in computing the 20 percent requirement.

*i.* A nursing facility of 75 beds or more shall have a qualified nurse on duty 24 hours per day, seven days a week. (II, III)

*j.* In facilities under 75 beds, if the health service supervisor is a licensed practical nurse, the facility shall employ a registered nurse, for at least four hours each week for consultation, who must be on duty at the same time as the health service supervisor. (II, III)

(1) This shall be an on-site consultation and documentation shall be made of the visit. (III)

(2) The registered nurse-consultant shall have responsibilities clearly outlined in a written agreement with the facility. (III)

(3) Consultation shall include but not be limited to the following: counseling the health service supervisor in the management of the health services; (III) reviewing and evaluating the health services in determining that the needs of the residents are met; (II, III) conducting a review of medications at least monthly if the facility does not employ a registered nurse part-time. (II, III)

*k.* Facilities with 75 or more beds must employ a health service supervisor who is a registered nurse. (II)

*l.* There shall be at least two people who shall be capable of rendering nursing service, awake, dressed, and on duty at all times. (II)

*m.* Physician's orders shall be implemented by qualified personnel. (II, III)

**58.11(3)** *Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse.* The facility shall comply with the requirements found in Iowa Code section 135C.33 and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)

[ARC 0903C, IAB 8/7/13, effective 9/11/13; ARC 5421C, IAB 2/10/21, effective 3/17/21]

#### **481—58.12(135C) Admission, transfer, and discharge.**

##### **58.12(1)** *General admission policies.*

*a.* No resident shall be admitted or retained in a nursing facility who is in need of greater services than the facility can provide. (II, III)

*b.* No nursing facility shall admit more residents than the number of beds for which it is licensed, except guest rooms for visitors. (II, III)

*c.* There shall be no more beds erected than is stipulated on the license. (II, III)

*d.* There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

*e.* The admission of a resident to a nursing facility shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

*f.* The admission of a resident shall not grant the nursing facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the facility as required by these rules. (III)

g. A nursing facility shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the nursing facility belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity.

l. Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a potential veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services.

If a resident is eligible for benefits through the United States Department of Veterans Affairs or other third-party payor, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II, III)

**58.12(2) Discharge or transfer.**

a. Prior notification shall be made to the resident, as well as the resident's next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the nursing facility for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such a discharge or transfer. (II, III)

d. Advance notification will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 58.15(2) "k" of these rules will accompany the resident. (II, III)

f. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

**481—58.13(135C) Contracts.** Each contract shall:

**58.13(1)** State the base rate or scale per day or per month, the services included, and the method of payment; (III)

**58.13(2)** Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. Furthermore, the contract shall: (III)

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in 58.13(3); (III)

b. State the method of payment of additional charges; (III)

*c.* Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

*d.* State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

**58.13(3)** Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the nursing assessment at the time of admission, which is determined in consultation with the administrator; (III)

**58.13(4)** Include the total fee to be charged initially to the specific resident; (III)

**58.13(5)** State the conditions whereby the facility may make adjustments to the facility's overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

*a.* Written notification to the resident, or responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to effective date of such changes; (III)

*b.* Notification to the resident, or responsible party when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

**58.13(6)** State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

**58.13(7)** State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

*a.* The facility shall ask the resident or responsible party if the resident wants the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

*b.* The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

**58.13(8)** State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

**58.13(9)** State the conditions of voluntary discharge or transfer; (III)

**58.13(10)** Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

**58.13(11)** Each party shall receive a copy of the signed contract. (III)

#### **481—58.14(135C) Medical services.**

**58.14(1)** Each resident in a nursing facility shall designate a licensed physician who may be called when needed. Professional management of a resident's care shall be the responsibility of the hospice program when:

*a.* The resident is terminally ill, and

*b.* The resident has elected to receive hospice services under the federal Medicare program from a Medicare-certified hospice program, and

*c.* The facility and the hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of hospice care.

**58.14(2)** Each resident admitted to a nursing facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical

and discharge summary may be made part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (III)

**58.14(3)** Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

**58.14(4)** Rescinded, effective 7/14/82.

**58.14(5)** The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

**58.14(6)** A schedule listing the names and telephone numbers of the physicians shall be posted in each nursing station. (III)

**58.14(7)** Residents shall be admitted to a nursing facility only on a written order signed by a physician certifying that the individual being admitted requires no greater degree of nursing care than the facility is licensed to provide. (III)

**58.14(8)** Physician delegation of tasks. Each resident, including private pay residents, shall be visited by or shall visit the resident's physician at least twice a year. The year period shall be measured from the date of admission and is not to include preadmission physicals.

*a.* For a skilled nursing patient, the resident must be seen by a physician for the initial comprehensive visit. Additional visits are required at least once every 30 days for 90 days after admission and at least once every 60 days thereafter. After the initial comprehensive visit, alternate required visits may be performed by an advanced registered nurse practitioner, clinical nurse specialist or physician assistant who is working in collaboration with a physician, as outlined in Table 1. (III)

*b.* Notwithstanding the provisions of 42 CFR 483.40, any required physician task or visit in a nursing facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with a physician, as outlined in Table 1. (III)

*c.* In dually certified skilled nursing/nursing facilities, the advanced registered nurse practitioner, clinical nurse specialist, and physician assistant must follow the skilled nursing facility requirements for services for skilled nursing facility stays. For nursing facility stays in skilled nursing/nursing facilities, any required physician task or visit may be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant working in collaboration with the physician. (III)

*d.* Nurse practitioners, clinical nurse specialists, and physician assistants may perform other tasks that are not reserved to the physician such as visits outside the normal schedule needed to address new symptoms or other changes in medical status. (III)

Table 1: Authority for non-physician practitioners to perform visits, sign orders, and sign certifications/recertifications when permitted by state law\*

	Initial Comprehensive Visit/Orders	Other Required Visits <sup>1</sup>	Other Medically Necessary Visits and Orders <sup>2</sup>	Certification/Recertification
<b>Skilled Nursing Facilities</b>				
Physician assistant, nurse practitioner and clinical nurse specialist employed by the facility	May not perform/May not sign	May perform alternate visits	May perform and sign	May not sign
Physician assistant, nurse practitioner and clinical nurse specialist not a facility employee	May not perform/May not sign	May perform alternate visits	May perform and sign	May sign subject to state requirements

	Initial Comprehensive Visit/Orders	Other Required Visits <sup>1</sup>	Other Medically Necessary Visits and Orders <sup>2</sup>	Certification/Recertification
Nursing Facilities				
Nurse practitioner, clinical nurse specialist, and physician assistant employed by the facility	May not perform/May not sign	May not perform	May perform and sign	Not applicable <sup>+</sup>
Nurse practitioner, clinical nurse specialist, and physician assistant not a facility employee	May perform/May sign	May perform	May perform and sign	Not applicable <sup>+</sup>

\*As permitted by state law governing the scope and practice of nurse practitioners, clinical nurse specialists, and physician assistants.

<sup>1</sup> Other required visits include the skilled nursing resident monthly visits that may be alternated between physician and advanced registered nurse practitioners, clinical nurse specialists, or physician assistants after the initial comprehensive visit is completed.

<sup>2</sup> Medically necessary visits may be performed prior to the initial comprehensive visit.

<sup>+</sup> This requirement relates specifically to coverage of Part A Medicare stays, which can take place only in a Medicare-certified skilled nursing facility.

[ARC 1048C, IAB 10/2/13, effective 11/6/13; ARC 1398C, IAB 4/2/14, effective 5/7/14]

#### 481—58.15(135C) Records.

**58.15(1) Resident admission record.** The licensee shall keep a permanent record on all residents admitted to a nursing facility with all entries current, dated, and signed. This shall be a part of the resident clinical record. (III) The admission record form shall include:

- a. Name and previous address of resident; (III)
- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of next of kin or legal representative; (III)
- g. Name, address, and telephone number of person to be notified in case of emergency; (III)
- h. Mortician's name, telephone number, and address; (III)
- i. Pharmacist's name, telephone number, and address. (III)

**58.15(2) Resident clinical record.** There shall be a separate clinical record for each resident admitted to a nursing facility with all entries current, dated, and signed. (III) The resident clinical record shall include:

- a. Admission record; (III)
- b. Admission diagnosis; (III)
- c. Physical examination: The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, tuberculosis status, physical examination, diagnosis, statement of chief complaints, estimation of restoration potential and results of any diagnostic procedures. The report of the physical examination shall be signed by the physician. (III)
- d. Physician's certification that the resident requires no greater degree of nursing care than the facility is licensed to provide; (III)
- e. Physician's orders for medication, treatment, and diet in writing and signed by the physician quarterly; (III)
- f. Progress notes.
  - (1) Physician shall enter a progress note at the time of each visit; (III)

(2) Other professionals, i.e., dentists, social workers, physical therapists, pharmacists, and others shall enter a progress note at the time of each visit; (III)

g. All laboratory, X-ray, and other diagnostic reports; (III)

h. Nurse's record including:

(1) Admitting notes including time and mode of transportation; room assignment; disposition of valuables; symptoms and complaints; general condition; vital signs; and weight; (II, III)

(2) Routine notes including physician's visits; telephone calls to and from the physician; unusual incidents and accidents; change of condition; social interaction; and P.R.N. medications administered including time and reason administered, and resident's reaction; (II, III)

(3) Discharge or transfer notes including time and mode of transportation; resident's general condition; instructions given to resident or legal representative; list of medications and disposition; and completion of transfer form for continuity of care; (II, III)

(4) Death notes including notification of physician and family to include time, disposition of body, resident's personal possessions and medications; and complete and accurate notes of resident's vital signs and symptoms preceding death; (III)

i. Medication record.

(1) An accurate record of all medications administered shall be maintained for each resident. (II, III)

(2) Schedule II drug records shall be kept in accordance with state and federal laws; (II, III)

j. Death record. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)

k. Transfer form.

(1) The transfer form shall include identification data from the admission record, name of transferring institution, name of receiving institution, and date of transfer; (III)

(2) The nurse's report shall include resident attitudes, behavior, interests, functional abilities (activities of daily living), unusual treatments, nursing care, problems, likes and dislikes, nutrition, current medications (when last given), and condition on transfer; (III)

(3) The physician's report shall include reason for transfer, medications, treatment, diet, activities, significant laboratory and X-ray findings, and diagnosis and prognosis; (III)

l. Consultation reports shall indicate services rendered by allied health professionals in the facility or in health-centered agencies such as dentists, physical therapists, podiatrists, oculists, and others. (III)

**58.15(3) Resident personal record.** Personal records may be kept as a separate file by the facility.

a. Personal records may include factual information regarding personal statistics, family and responsible relative resources, financial status, and other confidential information.

b. Personal records shall be accessible to professional staff involved in planning for services to meet the needs of the resident. (III)

c. When the resident's records are closed, the information shall become a part of the final record. (III)

d. Personal records shall include a duplicate copy of the contract(s). (III)

**58.15(4) Incident record.**

a. Each nursing facility shall maintain an incident record report and shall have available incident report forms. (III)

b. Report of incidents shall be in detail on a printed incident report form. (III)

c. The person in charge at the time of the incident shall prepare and sign the report. (III)

d. The report shall cover all accidents where there is apparent injury or where hidden injury may have occurred. (III)

e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)

f. A copy of the incident report shall be kept on file in the facility. (III)

**58.15(5) Retention of records.**

- a. Records shall be retained in the facility for five years following termination of services. (III)
- b. Records shall be retained within the facility upon change of ownership. (III)
- c. Rescinded, effective 7/14/82.
- d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

**58.15(6) Reports to the department.** The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

**58.15(7) Personnel record.**

- a. An employment record shall be kept for each employee, consisting of the following information: name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, criminal history and dependent adult abuse background checks, and date and reason for discharge or resignation. (III)
- b. The personnel records shall be made available for review upon request by the department. (III)

**481—58.16(135C) Resident care and personal services.**

**58.16(1)** Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

**58.16(2)** Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

**58.16(3)** Residents shall have clean clothing as needed to present a neat appearance, to be free of odors, and to be comfortable. Clothing shall be based on resident choice and shall be appropriate to residents' activities and to the weather. (III)

**58.16(4)** Rescinded, effective 7/14/82.

**58.16(5)** Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

**58.16(6)** Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

**58.16(7)** Rescinded, effective 7/14/82.

**58.16(8)** Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

**58.16(9)** Except for those who request differently, residents who are not bedfast shall be fully dressed each day to maintain self-esteem and promote the residents' normal lifestyles. (III)

**58.16(10)** Residents shall receive a bath of their choice, based on the facility's accommodations, as needed to maintain proper hygiene. (II, III)

**481—58.17** Rescinded, effective 7/14/82.

**481—58.18(135C) Nursing care.**

**58.18(1)** Individual health care plans shall be based on resident treatment decisions, the nature of the illness or disability, treatment, and care prescribed. Goals shall be developed by each discipline providing service, treatment, and care. These plans shall be in writing, revised as necessary, and kept current. They shall be made available to all those rendering the services and for review by the department. (III)

**58.18(2)** Rescinded IAB 4/2/14, effective 5/7/14.

**58.18(3)** The facility shall provide resident and family education as an integral part of restorative and supportive care. (III)

**58.18(4)** The facility shall provide prompt response from qualified staff for the resident's use of the nurse call system. (II, III) (Prompt response being considered as no longer than 15 minutes.)

[ARC 1398C, IAB 4/2/14, effective 5/7/14]

**481—58.19(135C) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:

**58.19(1) *Activities of daily living.***

- a. Bathing; (II, III)
- b. Daily oral hygiene (denture care); (II, III)
- c. Routine shampoo; (II, III)
- d. Nail care; (III)
- e. Shaving; (III)
- f. Daily care and application of prostheses (glasses, hearing aids, glass eyes, limb prosthetics, braces, or other assistive devices); (II, III)
  - g. Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)
  - h. Daily routine range of motion; (II, III)
  - i. Mobility (assistance with wheelchair, mechanical lift, or other means of locomotion); (I, II, III)
  - j. Elimination.
    - (1) Assistance to and from the bathroom and perineal care; (II, III)
    - (2) Bedpan assistance; (II, III)
    - (3) Care for incontinent residents; (II, III)
    - (4) Bowel and bladder training programs including in-dwelling catheter care (i.e., insertion and irrigation), enema and suppository administration, and monitoring and recording of intake and output, including solid waste; (I, II, III)
  - k. Colostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
  - l. Ileostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
  - m. All linens necessary; (III)
  - n. Nutrition and meal service.
    - (1) Regular, therapeutic, modified diets, and snacks; (I, II, III)
    - (2) Mealtime preparation of resident; (II, III)
    - (3) Assistance to and from meals; (II, III)
    - (4) In-room meal service or tray service; (II, III)
    - (5) Assistance with food preparation and meal assistance including total assistance if needed; (II, III)
    - (6) Assistance with adaptive devices; (II, III)
    - (7) Enteral nutrition (to be performed by a registered nurse or licensed practical nurse only); (I, II, III)
    - (8) Sufficient fluid intake to maintain proper hydration and health; (I, II, III)
  - o. Promote initiation of self-care for elements of resident care; (II, III)
  - p. Oral suctioning (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse). (I, II)

**58.19(2) *Medication and treatment.***

- a. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I, II)
- b. Provision of the appropriate care and treatment of wounds, including pressure sores, to promote healing, prevent infection, and prevent new sores from developing; (I, II)
- c. Blood glucose monitoring; (I, II)
- d. Vital signs, blood pressure, and weights; (I, II)
- e. Ambulation and transfer; (II, III)
- f. Provision of restraints; (I, II)
- g. Administration of oxygen (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II)
- h. Provision of all treatments; (I, II, III)

- i.* Provision of emergency medical care, including arranging for transportation, in accordance with written policies and procedures of the facility; (I, II, III)
- j.* Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III)  
[ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 2560C, IAB 6/8/16, effective 7/13/16]

**481—58.20(135C) Duties of health service supervisor.** Every nursing facility shall have a health service supervisor who shall:

- 58.20(1)** Direct the implementation of the physician's orders; (I, II)
- 58.20(2)** Plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs and choices, where practicable, are met; (II, III)
- 58.20(3)** Review the health care needs and choices, where practicable, of each resident admitted to the facility and assist the attending physician in planning for the resident's care; (II, III)
- 58.20(4)** Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident's family or the resident's legal representative, and others in accordance with instructions of the attending physician as follows:
  - a.* The written health care plan, based on the assessment and reassessment of the resident's health needs and choices, where practicable, is personalized for the individual resident and indicates care to be given, goals to be accomplished, and methods, approaches, and modifications necessary to achieve best results; (III)
  - b.* The health service supervisor is responsible for preparing, reviewing, supervising the implementation, and revising the written health care plan; (III)
  - c.* The health care plan is readily available for use by all personnel caring for the resident; (III)
- 58.20(5)** Initiate preventative and restorative nursing procedures for each resident so as to achieve and maintain the highest possible degree of function, self-care, and independence based on resident choice, where practicable; (II, III)
- 58.20(6)** Supervise health services personnel to ensure they perform the following restorative measures in their daily care of residents:
  - a.* Maintaining good bodily alignment and proper positioning; (II, III)
  - b.* Making every effort to keep the resident active except when contraindicated by physician's orders, and encouraging residents to achieve independence in activities of daily living by teaching self-care, transfer, and ambulation activities; (III)
  - c.* Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests as necessary; (III)
  - d.* Assisting residents to carry out prescribed therapy exercises between visits of the therapist; (III)
  - e.* Assisting residents with routine range of motion exercises; (III)
- 58.20(7)** Plan and conduct nursing staff orientation and in-service programs and provide for training of nurse's aides; (III)
- 58.20(8)** Plan with the resident and the resident's physician and family and health-related agencies for the care of the resident upon discharge; (III)
- 58.20(9)** Designate a responsible person to be in charge during absences; (III)
- 58.20(10)** Be responsible for all assignments and work schedules for all health services personnel to ensure that the health needs of the residents are met; (III)
- 58.20(11)** Ensure that all nurse's notes are descriptive of the care rendered including the resident's response; (III)
- 58.20(12)** Visit each resident routinely to be knowledgeable of the resident's current condition; (III)
- 58.20(13)** Evaluate in writing the performance of each individual on the health care staff on at least an annual basis. This evaluation shall be available for review in the facility to the department; (III)
- 58.20(14)** Keep the administrator informed of the resident's status; (III)
- 58.20(15)** Teach and coordinate rehabilitative health care including activities of daily living, promotion and maintenance of optimal physical and mental functioning; (III)

**58.20(16)** Supervise serving of meals to ensure that individuals unable to assist themselves are promptly fed and that special eating adaptive devices are available as needed; (II, III)

**58.20(17)** Make available a nursing procedure manual which shall include all procedures practiced in the facility; (III)

**58.20(18)** Participate with the administrator in the formulation of written policies and procedures for resident services; (III)

**58.20(19)** The person in charge shall immediately notify the family of any accident, injury, or adverse change in the resident's condition requiring physician's notification. (III)

**481—58.21(135C) Drugs, storage, and handling.**

**58.21(1)** Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

*a.* A cabinet with a lock, convenient to nursing service, shall be provided and used for storage of all drugs, solutions, and prescriptions; (III)

*b.* The drug storage cabinet shall be kept locked when not in use; (III)

*c.* The medication cabinet key shall be in the possession of the person directly responsible for issuing medications; (II, III)

*d.* Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a three-day supply and a missing dose can be readily detected. (II)

**58.21(2)** Drugs for external use shall be stored separately from drugs for internal use. (III)

**58.21(3)** Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items. A method for locking these medications shall be provided. (III)

**58.21(4)** All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

**58.21(5)** All flammable materials shall be specially stored and handled in accordance with applicable local and state fire regulations. (II)

**58.21(6)** A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

*a.* The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

*b.* This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

*c.* Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved nurse aide course, nurse aide training and testing program or nurse aide competency examination.

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

*d.* A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

(4) Successfully complete a department-approved nurse aide competency evaluation.

*e.* A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph “*c*” of this subrule do not apply to this individual.

**58.21(7)** Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, (II) unless the unit dose system is used.

**58.21(8)** An accurate written record of medications administered shall be made by the individual administering the medication. (III)

**58.21(9)** Records shall be kept of all Schedule II drug medications received and dispensed in accordance with the controlled drug and substance Act. (III)

**58.21(10)** Any unusual resident reaction shall be reported to the physician at once. (II)

**58.21(11)** A policy shall be established by the facility in conjunction with a licensed pharmacist to govern the distribution of prescribed medications to residents who are on leave from the facility. (III)

*a.* Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 58.21(14) “*a*,” non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident’s name, the facility, the medication, its strength, dose, and time of administration.

*b.* Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

*c.* Medication distributed as above may be issued only by a nurse responsible for administering medication. (I, II, III)

**58.21(12)** Emergency medications. A nursing facility shall provide emergency medications pursuant to the following requirements: (III)

*a.* Prescription drugs as well as nonprescription items must be prescribed or approved by the physician, in consultation with the pharmacist, who provides emergency service to the facility; (III)

*b.* The emergency medications shall be stored in an accessible place; (III)

*c.* A list of the emergency medications and quantities of each item shall be maintained by the facility; (III)

*d.* The container holding the emergency medications shall be closed with a seal which may be broken when drugs are required in an emergency or for inspection; (III)

*e.* Any item removed from the emergency medications shall be replaced within 48 hours; (III)

*f.* A permanent record shall be kept of each time the emergency medications are used; (III)

*g.* The emergency medications shall be inspected by a pharmacist at least once every three months to determine the stability of items. (III)

**58.21(13)** Drug handling.

*a.* Bulk supplies of prescription drugs shall not be kept in a nursing facility unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

*b.* Inspection of drug storage condition shall be made by the health service supervisor and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the nurse and pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician’s order, and drugs improperly stored. (III)

*c.* If the facility permits licensed nurses to dilute or reconstitute drugs at the nursing station, distinctive supplementary labels shall be available for the purpose. The notation on the label shall be so made as to be indelible. (III)

*d.* Dilution and reconstitution of drugs and their labeling shall be done by the pharmacist whenever possible. If not possible, the following shall be carried out only by the licensed nurse:

(1) Specific directions for dilution or reconstitution and expiration date should accompany the drug; (III)

(2) A distinctive supplementary label shall be affixed to the drug container when diluted or reconstituted by the nurse for other than immediate use. (III) The label shall bear the following: resident's name, dosage and strength per unit/volume, nurse's name, expiration date, and date and time of dilution. (III)

**58.21(14) Drug safeguards.**

*a.* All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

*b.* Medication containers having soiled, damaged, illegible or makeshift labels, or medication samples shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

*c.* There shall be no medications or any solution in unlabeled containers. (II, III)

*d.* The medications of each resident shall be kept or stored in the originally received containers. (II, III)

*e.* Labels on containers shall be clearly legible and firmly affixed. No label shall be superimposed on another label of a drug container. (II, III)

*f.* When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

*g.* Unused prescription drugs prescribed for residents who are deceased shall be returned to the supplying pharmacist. (III)

*h.* Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

*i.* No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

*j.* Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

*k.* There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by the responsible nurse with a witness and a notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

*l.* All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The physician, in consultation with the pharmacist serving the home, shall institute policies and provide procedures for review and endorsement of stop orders on drugs. This policy shall be conveniently located for personnel administering medications. (II, III)

*m.* No resident shall be allowed to keep possession of any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

*n.* Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedroom, but locked storage must be provided. (II)

*o.* No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

*p.* A qualified nurse shall:

(1) Establish a medication schedule system which identifies the time and dosage of each medication prescribed for each resident, is based on the resident's desired routine, and is approved by the resident's physician. (II, III)

(2) Establish a medication record containing the information specified above needed to monitor each resident's drug regimen. (II, III)

*q.* Telephone orders shall be taken by a qualified nurse. Orders shall be written into the resident's record and signed by the person receiving the order. Telephone orders shall be submitted to the physician for signature within 48 hours. (III)

*r.* A pharmacy operating in connection with a nursing facility shall comply with the provisions of the pharmacy law requiring registration of pharmacies and the regulations of the Iowa board of pharmacy examiners. (III)

*s.* In a nursing facility with a pharmacy or drug supply, service shall be under the personal supervision of a pharmacist licensed to practice in the state of Iowa. (III)

**58.21(15) Drug administration.**

*a.* Injectable medications shall be administered as permitted by Iowa law by a qualified nurse, physician, pharmacist, or physician assistant (PA). In the case of a resident who has been certified by the resident's physician or physician assistant (PA) as capable of taking the resident's own insulin, the resident may inject the resident's own insulin. (II)

*b.* An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

*c.* The health service supervisor shall be responsible for the supervision and direction of all personnel administering medications. (II)

[ARC 1050C, IAB 10/2/13, effective 11/6/13]

**481—58.22(135C) Rehabilitative services.** Rehabilitative services shall be provided to maintain function or improve the resident's ability to carry out the activities of daily living.

**58.22(1) Physical therapy services.**

*a.* Each facility shall have a written agreement with a licensed physical therapist to provide physical therapy services. (III)

*b.* Physical therapy shall be rendered only by a physical therapist licensed to practice in the state of Iowa. All personnel assisting with the physical therapy of residents must be under the direction of a licensed physical therapist. (II, III)

*c.* The licensed physical therapist shall:

(1) Evaluate the resident and prepare a physical therapy treatment plan conforming to the medical orders and goals; (III)

(2) Consult with other personnel in the facility who are providing resident care and plan with them for the integration of a physical therapy treatment program into the overall health care plan; (III)

(3) Instruct the nursing personnel responsible for administering selected restorative procedures between treatments; (III)

(4) Present programs in the facility's in-service education programs. (III)

*d.* Treatment records in the resident's medical chart shall include:

(1) The physician's prescription for treatment; (III)

(2) An initial evaluation note by the physical therapist; (III)

(3) The physical therapy care plan defining clearly the long-term and short-term goals and outlining the current treatment program; (III)

(4) Notes of the treatments given and changes in the resident's condition; (III)

(5) A complete discharge summary to include recommendations for nursing staff and family. (III)

*e.* There shall be adequate facilities, space, appropriate equipment, and storage areas as are essential to the treatment or examinations of residents. (III)

**58.22(2) Other rehabilitative services.**

*a.* The facility shall arrange for specialized and supportive rehabilitative services when such services are ordered by a physician. (III) These may include audiology and occupational therapy.

- b.* Audiology services shall be under the direction of a person licensed in the state of Iowa by the board of speech pathology and audiology. (II, III)
- c.* Occupational therapy services shall be under the direction of a qualified occupational therapist who is currently registered by the American Occupational Therapy Association. (II, III)
- d.* The appropriate professional shall:
  - (1) Develop the treatment plan and administer or direct treatment in accordance with the physician's prescription and rehabilitation goals; (III)
  - (2) Consult with other personnel within the facility who are providing resident care and plan with them for the integration of a treatment program into the overall health care plan. (III)

**481—58.23(135C) Dental, diagnostic, and other services.****58.23(1) Dental services.**

- a.* The nursing facility personnel shall assist residents to obtain regular and emergency dental services. (III)
- b.* Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)
- c.* Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)
- d.* All dental reports or progress notes shall be included in the clinical record. (III)
- e.* Nursing personnel shall assist the resident in carrying out dentist's recommendations. (III)
- f.* Dentists shall be asked to participate in the in-service program of the facility. (III)

**58.23(2) Diagnostic services.**

- a.* The nursing facility shall make provisions for promptly securing required clinical laboratory, X-ray, and other diagnostic services. (III)
- b.* All diagnostic services shall be provided only on the written, signed order of a physician. (III)
- c.* Agreements shall be made with the local hospital laboratory or independent laboratory to perform specific diagnostic tests when they are required. (III)
- d.* Transportation arrangements for residents shall be made, when necessary, to and from the source of service. (III)
- e.* Copies of all diagnostic reports shall be requested by the facility and included in the resident's clinical record. (III)
- f.* The physician ordering the specific diagnostic service shall be promptly notified of the results. (III)
- g.* Simple tests such as customarily done by nursing personnel for diabetic residents may be performed in the facility. (III)

**58.23(3) Other services.**

- a.* The nursing facility shall assist residents to obtain such supportive services as requested by the physician. (III)
- b.* Transportation arrangements shall be made when necessary. (III)
- c.* Services could include the need for prosthetic devices, glasses, hearing aids, and other necessary items. (III)

**481—58.24(135C) Dietary.**

**58.24(1) Organization of dietetic services.** The facility shall meet the needs of the residents and provide the services listed in this standard. If a service is contracted out, the contractor shall meet the same standard. A written agreement shall be formulated between the facility and the contractor and shall convey to the department the right to inspect the food service facilities of the contractor. (III)

- a.* There shall be written policies and procedures for dietetic services that include staffing, nutrition, menu planning, therapeutic diets, preparation, food service, ordering, receiving, storage, sanitation, and staff hygiene. The policies and procedures shall be made available for use by dietetic services. (III)

*b.* There shall be written job descriptions for each position in dietetic services. The job descriptions shall be made available for use by dietetic services. (III)

**58.24(2) Dietary staffing.**

*a.* The facility shall employ a qualified dietary supervisor who:

- (1) Is a qualified dietitian as defined in 58.24(2)“e”; or
- (2) Is a graduate of a dietetic technician training program approved by the Academy of Nutrition and Dietetics; or
- (3) Is a certified dietary manager certified by the certifying board for dietary managers of the Association of Nutrition and Foodservice Professionals and maintains that credential through 45 hours of ANFP-approved continuing education; or
- (4) Has completed an ANFP-approved course curriculum necessary to take the certification examination required to become a certified dietary manager; or
- (5) Has documented evidence of at least two years’ satisfactory work experience in food service supervision and who is in an approved dietary manager association program and will successfully complete the program within 24 months of the date of enrollment; or
- (6) Has completed the 90-hour training course approved by the department and is a certified food protection manager who has received training from and passed a test that is part of an American National Standards Institute (ANSI)-accredited Certified Food Protection Manager Program. (II, III)

*b.* The supervisor shall have overall supervisory responsibility for dietetic services and shall be employed for a sufficient number of hours to complete management responsibilities that include:

- (1) Participating in regular conferences with the consultant dietitian, the administrator and other department heads; (III)
- (2) Writing menus with consultation from the dietitian and seeing that current menus are posted and followed and that menu changes are recorded; (III)
- (3) Establishing and maintaining standards for food preparation and service; (II, III)
- (4) Participating in selection, orientation, and in-service training of dietary personnel; (II, III)
- (5) Supervising activities of dietary personnel; (II, III)
- (6) Maintaining up-to-date records of residents identified by name, location and diet order; (III)
- (7) Visiting residents to learn individual needs and communicating with other members of the health care team regarding nutritional needs of residents when necessary; (II, III)
- (8) Keeping records of repairs of equipment in dietetic services. (III)

*c.* A minimum of one person with supervisory and management responsibility and the authority to direct and control food preparation and service shall be a certified food protection manager who has received training from and passed a test that is part of an American National Standards Institute (ANSI)-accredited Certified Food Protection Manager Program.

*d.* The facility shall employ sufficient supportive personnel to carry out the following functions:

- (1) Preparing and serving adequate amounts of food that are handled in a manner to be bacteriologically safe; (II, III)
- (2) Washing and sanitizing dishes, pots, pans and equipment at temperatures required by procedures described in the Food Code as defined in Iowa Code section 137F.2; (II, III)
- (3) Serving therapeutic diets as prescribed by the physician and following the planned menu. (II, III)

*e.* The facility may assign simultaneous duties in the kitchen and laundry, housekeeping, or nursing service to appropriately trained personnel. Proper sanitary and personal hygiene procedures shall be followed as outlined under the rules pertaining to staff hygiene. (II, III)

*f.* If the dietetic service supervisor is not a licensed dietitian, a consultant dietitian is required. The consultant dietitian shall be licensed by the state of Iowa pursuant to Iowa Code chapter 152A.

*g.* Consultants’ visits shall be scheduled to be of sufficient duration and at a time convenient to:

- (1) Record, in the resident’s medical record, any observations, assessments and information pertinent to medical nutrition therapy; (I, II, III)
- (2) Work with residents and staff on resident care plans; (III)

(3) Consult with the administrator and others on developing and implementing policies and procedures; (III)

(4) Write or approve general and therapeutic menus; (III)

(5) Work with the dietetic supervisor on developing procedures, recipes and other management tools; (III)

(6) Present planned in-service training and staff development for food service employees and others. Documentation of consultation shall be available for review in the facility by the department. (III)

*h.* In facilities licensed for more than 15 beds, dietetic services shall be available for a minimum of a 12-hour span extending from the time of preparation of breakfast through supper. (III)

**58.24(3) Nutrition and menu planning.**

*a.* Menus shall be planned and followed to meet the nutritional needs of each resident in accordance with the physician's orders and in consideration of the resident's choices and preferences. (II, III)

*b.* Menus shall be planned to provide 100 percent of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. A current copy of the Simplified Diet Manual or other suitable diet manual shall be available and used in the planning and serving of all meals. (II)

*c.* At least three meals or their equivalent shall be served daily at regular hours. (II)

(1) There shall be no more than a 14-hour span between a substantial evening meal and breakfast except as provided in subparagraph (3) below. (II, III)

(2) The facility shall offer snacks at bedtime daily. (II, III)

(3) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast of the following day. The current resident group must agree to this meal span and a nourishing snack must be served. (II)

*d.* Menus shall include a variety of foods prepared in various ways. (III)

*e.* Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic services department for easy use by persons purchasing, preparing and serving food. (III)

*f.* Records of menus as served shall be filed and maintained for 30 days and shall be available for review by department personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded. (III)

*g.* A file of tested recipes adjusted to the number of people to be served in the facility shall be maintained. (III)

*h.* Alternate foods shall be offered to residents who refuse the food served. (II, III)

**58.24(4) Therapeutic diets and nutritional status.**

*a.* The facility shall ensure that each resident has a nutritional assessment completed by the licensed dietitian within 14 days of admission that addresses the residents' medical condition and therapeutic dietary needs, desires and rights in regard to their nutritional plan. (I, II, III)

*b.* Therapeutic diets shall be prescribed by the resident's physician. A current edition of the Simplified Diet Manual or other suitable diet manual shall be readily available to physicians, nurses and dietetic services personnel. A current diet manual shall be used as a guide for writing menus for therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and reviewing procedures for preparation and service of food. (II, III)

*c.* Personnel responsible for planning, preparing and serving therapeutic diets shall receive instructions on those diets. (II, III)

*d.* The facility shall ensure that each resident maintains acceptable parameters of nutritional status, such as body weight, unless the resident's clinical condition demonstrates that this is not possible. (I, II, III)

**58.24(5) Food handling, preparation and service.** All food shall be handled, prepared and served in compliance with the requirements of the Food and Drug Administration Food Code adopted under provisions of Iowa Code section 137F.2. (I, II, III) In addition, the following shall apply.

- a. Methods used to prepare foods shall be those which conserve nutritive value and flavor and meet the taste preferences of the residents. (III)
- b. Foods shall be attractively served. (III)
- c. Foods shall be cut up, chopped, ground or blended to meet individual needs. (I, II, III)
- d. Self-help devices shall be provided as needed. (II, III)
- e. Disposables shall not be used routinely. Plasticware, china and glassware that are unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded. (II, III)
- f. All food that is transported through public corridors shall be covered. (III)
- g. Residents may be allowed in the food preparation area. (III)
- h. The food preparation area may be used as a dining area for residents, staff or food service personnel if the facility engages in person-directed care. (III)
- i. There shall be effective written procedures established for cleaning all work and serving areas. (III)
- j. A schedule of cleaning duties to be performed daily shall be posted. (III)
- k. An exhaust system and hood shall be clean, operational and maintained in good repair. (III)
- l. The food service area shall be located so it will not be used as a passageway by residents, guests or non-food service staff. (III)

**58.24(6) *Paid nutritional assistants.*** A paid nutritional assistant means an individual who meets the requirements of this subrule and who is an employee of the facility or an employee of a temporary employment agency employed by the facility. A facility may use an individual working in the facility as a paid nutritional assistant only if that individual has successfully completed a state-approved training program for paid nutritional assistants. (I, II, III)

a. *Training program requirements.*

- (1) A state-approved training program for paid nutritional assistants must include, at a minimum, eight hours of training in the following areas:
  - 1. Feeding techniques.
  - 2. Assistance with feeding and hydration.
  - 3. Communication and interpersonal skills.
  - 4. Appropriate responses to resident behavior.
  - 5. Safety and emergency procedures, including the Heimlich maneuver.
  - 6. Infection control.
  - 7. Resident rights.
  - 8. Recognizing changes in residents that are inconsistent with their normal behavior and reporting these changes to the supervisory nurse.
- (2) In addition to the training program requirements specified in subparagraph (1), the training program must include at least four hours of classroom study, two hours of supervised laboratory work, and two hours of supervised clinical experience.
- (3) A facility that offers a paid nutritional assistant training program must provide sufficient supplies in order to teach the objectives of the course.
- (4) All paid nutritional assistant training program instructors shall be registered nurses. Other qualified health care professionals may assist the instructor in teaching the classroom portion and clinical or laboratory experience. The ratio of students to instructor shall not exceed ten students per instructor in the clinical setting.
- (5) Each individual enrolled in a paid nutritional assistant training program shall complete a 50-question multiple choice written test and must obtain a score of 80 percent or higher. In addition, the individual must successfully perform the feeding of a resident in a clinical setting. A registered nurse shall conduct the final competency determination.
- (6) If an individual does not pass either the written test or competency demonstration, the individual may retest the failed portion a second time. If the individual does not pass either the written test or competency demonstration portion the second time, the individual shall not be allowed to retest.

*b. Program approval.* A facility or other entity may not offer or teach a paid nutritional assistant training program until the department has approved the program. Individuals trained in a program not approved by the department will not be allowed to function as paid nutritional assistants.

(1) A facility or other institution offering a paid nutritional assistant training program must provide the following information about the training program to the department before offering the program or teaching paid nutritional assistants:

1. Policies and procedures for program administration.
2. Qualifications of the instructors.
3. Maintenance of program records, including attendance records.
4. Criteria for determining competency.
5. Program costs and refund policies.
6. Lesson plans, including the objectives to be taught, skills demonstrations, assignments, quizzes, and classroom, laboratory and clinical hours.

(2) The facility or other institution offering a paid nutritional assistant training program must submit the materials specified in subparagraph (1) for department review. The department shall, within ten days of receipt of the material, advise the facility or institution whether the program is approved, or request additional information to assist the department in determining whether the curriculum meets the requirements for a paid nutritional assistant training program. Before approving any paid nutritional assistant training program, the department shall determine whether the curriculum meets the requirements specified in this subrule. The department shall maintain a list of facilities and institutions eligible to provide paid nutritional assistant training. (I, II, III)

(3) A facility shall maintain a record of all individuals who have successfully completed the required training program and are used by the facility as paid nutritional assistants. The individual shall complete the training program with a demonstration of knowledge and competency skills necessary to serve as a paid nutritional assistant. (I, II, III)

(4) The facility or other institution providing the training shall, within ten calendar days of an individual's successful completion of the training program, provide the individual with a signed and dated certificate of completion. A facility that employs paid nutritional assistants shall maintain on file copies of the completed certificate and skills checklist for each individual who has successfully completed the training program. (I, II, III)

*c. Working restrictions.*

(1) A paid nutritional assistant must work under the supervision of a registered nurse or a licensed practical nurse. In an emergency, a paid nutritional assistant must call a supervisory nurse on the resident call system for help. (I, II, III)

(2) A facility must ensure that a paid nutritional assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube, parenteral or intravenous feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. (I, II, III)

[ARC 2560C, IAB 6/8/16, effective 7/13/16]

#### **481—58.25(135C) Social services program.**

**58.25(1)** The administrator or designee shall be responsible for developing a written, organized orientation program for all residents. (III)

**58.25(2)** The program shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the medical or health care, recovery, and rehabilitation of the individual. (III)

**58.25(3)** The social services plan, including specific goals and regular evaluation of progress, shall be incorporated into the overall plan of care. (III)

#### **481—58.26(135C) Resident activities program.**

**58.26(1) *Organized activities.*** Each nursing facility shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

*a.* The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

*b.* The program shall include individual goals for each resident. (III)

*c.* The program shall include both group and individual activities. (III)

*d.* No resident shall be forced to participate in the activity program. (III)

*e.* The activity program shall include suitable activities for those residents unable to leave their rooms. (III)

*f.* The program shall be incorporated into the overall health plan and shall be designed to meet the goals as written in the plan.

**58.26(2) *Coordination of activities program.***

*a.* Each nursing facility shall employ a person to direct the activities program. (III)

<sup>1</sup>*b.* Staffing for the activity program shall be provided on the minimum basis of 35 minutes per licensed bed per week. (II, III)

*c.* The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

*d.* The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

*e.* There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

**58.26(3) *Duties of activity coordinator.*** The activity coordinator shall:

*a.* Have access to all residents' records excluding financial records; (III)

*b.* Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

*c.* Keep all necessary records including:

(1) Attendance; (III)

(2) Individual resident progress notes recorded at regular intervals (at least quarterly). A copy of these notes shall be placed in the resident's clinical record; (III)

(3) Monthly calendars, prepared in advance. (III)

*d.* Coordinate the activity program with all other services in the facility; (III)

*e.* Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

**58.26(4) *Supplies, equipment, and storage.***

*a.* Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III) These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc.

*b.* Storage shall be provided for recreational equipment and supplies. (III)

*c.* Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

<sup>1</sup> Objection filed 2/14/79; see Objection at end of chapter.

**481—58.27(135C) Certified volunteer long-term care ombudsman program.** A certified volunteer long-term care ombudsman appointed in accordance with Iowa Code section 231.45 as amended by

2013 Iowa Acts, Senate File 184, shall operate within the scope of the rules for volunteer ombudsmen promulgated by the office of long-term care ombudsman and Iowa department on aging.  
[ARC 1205C, IAB 12/11/13, effective 1/15/14]

**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

**58.28(1) Fire safety.**

*a.* All nursing facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

*b.* The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

**58.28(2) Safety duties of administrator.** The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

*a.* The plan shall be posted. (III)

*b.* In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

**58.28(3) Resident safety.**

*a.* Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when the resident is under direct supervision. (II, III)

*b.* Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

*c.* Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

*d.* Smoking shall be permitted only in posted areas. (II, III)

*e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)

*f.* Residents shall be protected against physical or environmental hazards to themselves. (I, II, III)  
[ARC 1398C, IAB 4/2/14, effective 5/7/14]

**481—58.29(135C) Resident care.**

**58.29(1)** There shall be a readily available supply of self-help and ambulation devices such as wheelchairs, walkers, and such other devices maintained in good repair that will meet the current needs of all residents. (III)

**58.29(2)** The facility shall ensure that each ambulatory resident has well-fitting shoes to provide support and prevent slipping. (III)

**58.29(3)** Equipment for personal care shall be maintained in a safe and sanitary condition. (II, III)

**58.29(4)** The expiration date for sterile equipment shall be exhibited on its wrappings. (III)

**58.29(5)** Residents who have been known to wander shall be provided with appropriate means of identification. (II, III)

**58.29(6)** Electric heating pads, blankets, or sheets shall be used only on the written order of a physician, when allowed by the Life Safety Code or applicable state or local fire regulations. (II, III)

**481—58.30** Rescinded, effective 7/14/82.

**481—58.31(135C) Housekeeping.**

**58.31(1)** Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

**58.31(2)** Each resident unit shall be cleaned on a routine schedule. (III)

**58.31(3)** All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

**58.31(4)** A hallway or corridor shall not be used for storage of equipment. (III)

**58.31(5)** All odors shall be kept under control by cleanliness and proper ventilation. (III)

**58.31(6)** Clothing worn by personnel shall be clean and washable. (III)

**58.31(7)** Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

**58.31(8)** All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

**58.31(9)** Polishes used on floors shall provide a nonslip finish. (III)

**58.31(10)** \*Throw or scatter rugs shall not be permitted. (III)

\*Objection. For text of Objection, see IAC Supp., Part I, 9/7/77. For text of Filed rules, 470—Chapter 58, see IAC Supp. 10/5/77.

**58.31(11)** Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

**58.31(12)** Residents shall not have access to storage areas for all cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials. (II, III)

**58.31(13)** Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

**58.31(14)** Definite procedures shall be established for training housekeeping personnel. (III)

**58.31(15)** Rescinded IAB 12/6/06, effective 1/10/07.

**58.31(16)** There shall be provisions for the cleaning and storage of housekeeping equipment and supplies for each nursing unit. (III)

**58.31(17)** Bathtubs, shower stalls, or lavatories shall not be used for laundering, cleaning of utensils and mops, or for storage. (III)

**58.31(18)** Bedside utensils shall be stored in enclosed cabinets. (III)

**58.31(19)** Kitchen sinks shall not be used for the cleaning of mops, soaking of laundry, cleaning of bedside utensils, nursing utensils, or dumping of wastewater. (III)

**58.31(20)** Personal possessions of residents which may constitute hazards to themselves or others shall be removed and stored. (III)

#### **481—58.32(135C) Maintenance.**

**58.32(1)** Each facility shall establish a maintenance program in writing to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. (III)

**58.32(2)** The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

**58.32(3)** Draperies and furniture shall be clean and in good repair. (III)

**58.32(4)** Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

**58.32(5)** The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the national electrical code. (III)

**58.32(6)** All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

**58.32(7)** Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. Documentation of these inspections shall be available for review. (III)

**58.32(8)** The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

**58.32(9)** The facility shall be kept free of flies, other insects, and rodents. (III)

**58.32(10)** Maintenance personnel.

*a.* A written program shall be established for the orientation of maintenance personnel. (III)

*b.* Maintenance personnel shall:

(1) Follow established written maintenance programs; (III)

(2) Be provided with appropriate, well-constructed, and properly maintained equipment. (III)

#### **481—58.33(135C) Laundry.**

**58.33(1)** All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

**58.33(2)** Except for related activities, the laundry room shall not be used for other purposes. (III)

**58.33(3)** Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

**58.33(4)** Residents' personal laundry shall be marked with an identification. (III)

**58.33(5)** Bed linens, towels, and washcloths shall be clean and stain-free. (III)

**481—58.34(135C) Garbage and waste disposal.**

**58.34(1)** All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

**58.34(2)** All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

**58.34(3)** All containers shall be thoroughly cleaned each time the containers are emptied. (III)

**58.34(4)** All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

**58.34(5)** Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

**481—58.35(135C) Buildings, furnishings, and equipment.**

**58.35(1) Buildings—general requirements.**

*a.* For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than seven feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

*b.* Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

*c.* All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

*d.* Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

*e.* Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

*f.* All fans located within seven feet of the floor shall be protected by screen guards of not more than one-half-inch mesh. (III)

*g.* Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

*h.* The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

*i.* No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates, except closets used for the storage of residents' clothing. (III)

**58.35(2) Furnishings and equipment.**

*a.* All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

*b.* All resident areas shall be decorated, painted, and furnished to provide a home-like atmosphere. (III)

*c.* Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

**58.35(3) Dining and living rooms.**

*a.* Every facility shall have a dining room and a living room easily accessible to all residents. (III)

- b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)
  - c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)
  - d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 58.35(3)“e” are met. (III)
  - e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment. (III)
  - f. Living rooms.
    - (1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)
    - (2) Living rooms shall be suitably provided with parlor furniture, television and radio receivers in good working order, recreational material such as games, puzzles, and cards, and reading material such as current newspapers and magazines. Furnishings and equipment of the room should be such as to allow group activities. (III)
    - (3) Card tables or game tables shall be made available. The tables should be of a height to allow a person seated in a wheelchair to partake in the games or card playing. (III)
    - (4) Chairs of proper height and appropriate to their use shall be provided for seating residents at game tables and card tables. (III)
  - g. Dining rooms.
    - (1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)
    - (2) Dining tables and chairs shall be provided. (III)
    - (3) Dining tables should be so constructed that a person seated in a wheelchair can dine comfortably. (III)
    - (4) Tables shall be of sturdy construction with smooth, durable, nonpermeable tops that can be cleaned with a detergent sanitizing solution. (III)
    - (5) Dining chairs shall be sturdy and comfortable. Some arm chairs should be provided for ease of movement for some residents. (III)
    - (6) Residents shall be encouraged to eat in the dining room. (III)
- 58.35(4) Bedrooms.**
- a. Each resident shall be provided with a standard, single, or twin bed that is substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. Seventy-five percent of the beds shall have a spring with an adjustable head and foot section. A resident shall have the right to sleep in a chair per the resident’s request and to have the bed removed from the room to allow for additional space. (III)
  - b. Each bed shall be equipped with the following: casters or glides unless a low bed and mattress are being used for fall precautions; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; clean, comfortable pillows of average size; and moisture-proof covers and sheets as necessary to keep the mattress and pillows dry and clean. (III)
  - c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)
  - d. There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident’s personal wishes shall be considered. (III)
  - e. There shall be drawer space for each resident’s clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)
  - f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)
  - g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)
  - h. Clothing shall be hung in closets or wardrobes available in each room. (III)

- i.* Beds shall not be placed with the head of the bed in front of a window or radiator. (III)
- j.* Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)
- k.* Reading lamps shall be provided each resident in the resident's room. (III)
- l.* Each room shall have sufficient accessible mirrors to serve the resident's needs. Mirrors are not required if the room is located in a CCDI unit and the mirrors cause concern for the resident. (III)
- m.* Sturdy, adjustable overbed tables shall be provided for each resident who is unable to eat in the dining room. (III)
- n.* Each resident bedroom shall have a door. The door shall be the swing type and shall not swing into the corridor. (III)

**58.35(5) Heating.** A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

**58.35(6) Water supply.**

- a.* Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)
- b.* Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)
- c.* A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)
- d.* The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)
- e.* Hot and cold running water under pressure shall be available in the facility. (III)
- f.* Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department of health. (III)

**58.35(7) Nonambulatory residents.**

- a.* All nonambulatory residents shall be housed on the grade level floor. (II, III)
- b.* These provisions in "a" above relating to nonambulatory residents are not applicable if the facility has a suitably sized elevator.

**481—58.36(135C) Family and employee accommodations.**

**58.36(1)** Children under 14 years of age shall not be allowed into the service areas. (III)

**58.36(2)** The residents' bedrooms shall not be occupied by employees or family members of the licensee. (III)

**58.36(3)** In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

**58.36(4)** In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

**58.36(5)** In all health care facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

**481—58.37(135C) Animals.** Animals may be permitted within the facility with prior approval of the department and under controlled conditions. (III)

**481—58.38(135C) Supplies.**

**58.38(1) Linen supplies.**

- a.* There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)
- b.* A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

**58.38(2) First-aid kit.** A first-aid emergency kit shall be available on each floor in every facility. (II, III)

**58.38(3) Supplies and equipment for nursing services.**

a. All nursing care equipment shall be properly sanitized or sterilized before use by another resident. (II)

b. There shall be disposable or one-time use items available with provisions for proper disposal to prevent reuse except as allowed by 58.10(8) "h," 481—paragraph 59.12(10) "h," or 481—paragraph 64.12(14) "h." (I, II, III)

c. Convenient, safe storage shall be provided for bath and toilet supplies, bathroom scales, mechanical lifts, and shower chairs. (III)

d. Sanitary and protective storage shall be provided for all equipment and supplies. (III)

e. All items that must be sterilized shall be autoclaved unless sterile disposable items are furnished which are promptly disposed of after a single use. (III)

f. Supplies and equipment for nursing and personal care sufficient in quantities to meet the needs of the residents shall be provided and, as a minimum, include the following: (III)

Bath basins	Rectal tubes
Soap containers	Catheters and catheterization equipment
Denture cups	Douche nozzle
Emesis basins	Oxygen therapy equipment
Mouthwash cups	Naso-gastric feeding equipment
Bedpans	Wheelchairs
Urinals	Moisture-proof draw sheets
Enema equipment	Moisture-proof pillow covers
Commodes	Moisture-proof mattress covers
Quart graduate measure	Foot tubs
Thermometer for measurement of bath water temperature	Metal pitcher
Oral thermometer	Disinfectant solutions
Rectal thermometer	Alcohol
Basins for sterilizing thermometers	Lubricating jelly
Basins for irrigations	Skin lotion
Asepto syringes	Applicators
Sphygmomanometer	Tongue blades
Paper towels	Toilet paper
Paper handkerchiefs	Rubber gloves or disposable gloves
Insulin syringes	Scales for nonambulatory patients
2 cc hypodermic syringes	Tourniquet
	Suction machine

Weight scales	Medicine dispensing containers
Hypodermic needles	Bandages
Stethoscope	Adhesive
Ice caps	Portable linen hampers
Hot water bottles	Denture identification equipment
	Tracheotomy care equipment

**481—58.39(135C) Residents’ rights in general.**

**58.39(1)** Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 58.39(2) to 58.39(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

**58.39(2)** Policies and procedures shall address the admission and retention of persons with histories of dangerous or disturbing behavior. For the purposes of the subrule, persons with histories of dangerous or disturbing behavior are those persons who have been found to be seriously mentally impaired pursuant to Iowa Code section 229.13 or 812.1 within six months of the request for admission to the facility. In addition to establishing the criteria for admission and retention of persons so defined, the policies and procedures shall provide for:

*a.* Reasonable precautions to prevent the resident from harming self, other residents, or employees of the facility.

*b.* Treatment of persons with mental illness as defined in Iowa Code section 229.1(1) and which is provided in accordance with the individualized health care plan.

*c.* Ongoing and documented staff training on individualized health care planning for persons with mental illness.

**58.39(3)** Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

*a.* Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

*b.* As changes occur in residents’ physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

**58.39(4)** Policies and procedures regarding the use of chemical and physical restraints shall define the use of said restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

**58.39(5)** Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

**58.39(6)** Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents’ records. (II)

**58.39(7)** Policies and procedures shall include a provision that each resident shall be fully informed of the resident’s rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility’s adoption or amendment of residents’ rights policies. (II)

*a.* The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

*b.* Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

*c.* A statement shall be signed by the resident, or the resident's responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of an intellectually disabled resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

*d.* In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

*e.* All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English speaking, deaf, or blind residents of such changes. (II)

**58.39(8)** Each resident or responsible party shall be fully informed in a contract as required in rule 481—58.13(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges including any charges for services not covered under the Title XIX program or not covered by the facility's basic per diem rate. (II)

**58.39(9)** Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the U.S. Department of Health and Human Services' protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or intellectually disabled individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

*a.* The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

*b.* The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

*c.* If the physician determines or in the case of a confused or intellectually disabled resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

*d.* The resident's plan of care shall be based on the physician's orders. It shall be developed upon admission by appropriate facility staff and shall include participation by the resident if capable. Residents shall be advised of alternative courses of care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives shall be elicited and honored if feasible.

*e.* Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the

possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

This rule is intended to implement Iowa Code section 135C.23(2).  
[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—58.40(135C) Involuntary discharge or transfer.**

**58.40(1) *Involuntary discharge or transfer permitted.*** A facility may involuntarily discharge or transfer a resident for only one of the following reasons:

- a. Medical reasons;
- b. The resident's welfare or that of other residents;
- c. Nonpayment for the resident's stay, as described in the contract for the resident's stay;
- d. Due to action pursuant to Iowa Code chapter 229;
- e. By reason of negative action by the Iowa department of human services; or
- f. By reason of negative action by the quality improvement organization (QIO). (I, II, III)

**58.40(2) *Medical reasons.*** Medical reasons for transfer or discharge shall be based on the resident's needs and shall be determined and documented in the resident's record by the primary care provider. Transfer or discharge may be required in order to provide a different level of care to the resident. (II)

**58.40(3) *Welfare of a resident.*** Welfare of a resident or that of other residents refers to a resident's social, emotional, or physical well-being. A resident may be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with other residents' needs and rights). Written documentation that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall include specific information to support this determination. (II)

**58.40(4) *Involuntary discharge or transfer prohibited—payment source.*** A resident shall not be transferred or discharged solely because the cost of the resident's care is being paid under Iowa Code chapter 249A or because the resident's source of payment is changing from private support to payment under Iowa Code chapter 249A. (I, II)

**58.40(5) *Notice.*** Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident and the responsible party. (II, III)

- a. The notice shall contain all of the following information:
  - (1) The stated reason for the proposed transfer or discharge. (II)
  - (2) The effective date of the proposed transfer or discharge. (II)
  - (3) A statement, in not less than 12-point type, that reads as follows:

You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing, in writing or verbally, with the Iowa department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department's receipt of your request and you will not be transferred before a final decision is rendered. Extension of the 14-day requirement may be permitted in emergency circumstances upon request to the department's designee. If you lose the hearing, you will not be transferred before the expiration of either (1) 30 days following your receipt of the original notice of the discharge or transfer, or (2) 5 days following final decision of such hearing, including the exhaustion of all appeals, whichever occurs later. To request a hearing or receive further information, call the department at (515)281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. (II)

- b. The notice shall be personally delivered to the resident and a copy placed in the resident's record. A copy shall also be transmitted to the department; the resident's responsible party; the resident's primary care provider; the person or agency responsible for the resident's placement, maintenance, and

care in the facility; and the department on aging's office of the long-term care ombudsman. The notice shall indicate that copies have been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent.

c. The notice required by paragraph 58.40(5) "a" shall be provided at least 30 days in advance of the proposed transfer or discharge unless one of the following occurs:

(1) An emergency transfer or discharge is mandated by the resident's health care needs and is in accordance with the written orders and medical justification of the primary care provider. Emergency transfers or discharges may also be mandated in order to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) The transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, the resident's primary care provider, and the person or agency responsible for the resident's placement, maintenance, and care in the facility.

(3) The discharge or transfer is the result of a final, nonappealable decision by the department of human services or the QIO.

d. A hearing requested pursuant to this subrule shall be held in accordance with subrule 58.40(7).

**58.40(6) Emergency transfer or discharge.** In the case of an emergency transfer or discharge, the resident must be given a written notice prior to or within 48 hours following the transfer or discharge. (II, III)

a. A copy of this notice shall be placed in the resident's file. The notice shall contain all of the following information:

- (1) The stated reason for the transfer or discharge. (II)
- (2) The effective date of the transfer or discharge. (II)
- (3) A statement, in not less than 12-point type, that reads as follows:

You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing, in writing or verbally, with the Iowa department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department's receipt of your request. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. (II)

b. The notice shall be personally delivered to the resident and a copy placed in the resident's record. A copy shall also be transmitted to the department; the resident's responsible party; the resident's primary care provider; the person or agency responsible for the resident's placement, maintenance, and care in the facility; and the department on aging's office of the long-term care ombudsman. The notice shall indicate that copies have been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent.

c. A hearing requested pursuant to this subrule shall be held in accordance with subrule 58.40(7). **58.40(7) Hearing.**

a. Request for hearing.

- (1) The resident must request a hearing within 7 days of receipt of the written notice.
- (2) The request must be made to the department, either in writing or verbally.

b. The hearing shall be held no later than 14 days after the department's receipt of the request unless either party requests an extension due to emergency circumstances.

c. Except in the case of an emergency discharge or transfer, a request for a hearing shall stay a transfer or discharge pending a final decision, including the exhaustion of all appeals. (II)

d. The hearing shall be heard by a department of inspections and appeals administrative law judge pursuant to Iowa Code chapter 17A and 481—Chapter 9. The hearing shall be public unless the resident

or resident's legal representative requests in writing that the hearing be closed. In a determination as to whether a transfer or discharge is authorized, the burden of proof by a preponderance of the evidence rests on the party requesting the transfer or discharge.

*e.* Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the facility, the resident, the responsible party, and the office of the long-term care ombudsman not later than 5 full business days after the department's receipt of the request. The notice shall also inform the facility and the resident or the responsible party that they have a right to appear at the hearing in person or be represented by an attorney or other individual. The appeal shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The office of the long-term care ombudsman shall have the right to appear at the hearing.

*f.* The administrative law judge's written decision shall be mailed by certified mail to the facility, resident, responsible party, and the office of the long-term care ombudsman within 10 working days after the hearing has been concluded.

*g.* If the basis for an involuntary transfer or discharge is the result of a negative action by the Iowa department of human services or the QIO, an appeal shall be filed with those agencies as appropriate. Continued payment shall be consistent with rules of those agencies.

**58.40(8) *Nonpayment.*** If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

**58.40(9) *Discussion of involuntary transfer or discharge.*** Within 48 hours after notice of involuntary transfer or discharge has been received by the resident, the facility shall discuss the involuntary transfer or discharge with the resident, the resident's responsible party, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

*a.* The facility administrator or other appropriate facility representative serving as the administrator's designee shall provide an explanation and discussion of the reasons for the resident's involuntary transfer or discharge. (II)

*b.* The content of the explanation and discussion shall be summarized in writing, shall include the names of the individuals involved in the discussion, and shall be made part of the resident's record. (II)

*c.* The provisions of this subrule do not apply if the involuntary transfer or discharge has already occurred pursuant to subrule 58.40(6) and emergency notice is provided within 48 hours.

**58.40(10) *Transfer or discharge planning.***

*a.* The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be transferred or discharged. (II)

*b.* To minimize the possible adverse effects of the involuntary transfer, the resident shall receive counseling services by the sending facility before the involuntary transfer and by the receiving facility after the involuntary transfer. Counseling shall be documented in the resident's record. (II)

*c.* The counseling requirement in paragraph 58.40(10) "b" does not apply if the discharge has already occurred pursuant to subrule 58.40(6) and emergency notice is provided within 48 hours.

*d.* Counseling, if required, shall be provided by a licensed mental health professional as defined in Iowa Code section 228.1(6). (II)

*e.* The health care facility that receives a resident who has been involuntarily transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

**58.40(11) *Transfer upon revocation of license or voluntary closure.*** Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department of inspections and appeals. In the case of the voluntary closure of a facility, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

**58.40(12) *Intrafacility transfer.***

*a.* Residents shall not be arbitrarily relocated from room to room within a licensed health care facility. (I, II) Involuntary relocation may occur only in the following situations, which shall be documented in the resident's record: (II)

- (1) Resident's incompatibility with or disturbance to other roommates.
  - (2) For the welfare of the resident or other residents of the facility.
  - (3) For medical, nursing or psychosocial reasons, as judged by the primary care provider, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.
  - (4) To allow a new admission to the facility that would otherwise not be possible due to separation of roommates by sex.
  - (5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX (Medicaid) assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.
  - (6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.
    - b.* Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or responsible party include:
      - (1) Change from private pay status to Title XIX, except as outlined in subparagraph 58.40(12) "a"(5). (II)
      - (2) As punishment or behavior modification, except as specified in subparagraph 58.40(12) "a"(1). (II)
      - (3) Discrimination on the basis of race or religion. (II)
    - c.* If intrafacility relocation is necessary for reasons outlined in paragraph 58.40(12) "a," the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or responsible party. (II)
    - d.* If emergency relocation is required in order to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition that necessitates emergency relocation, and such notification shall be documented. (II)
    - e.* A transfer to a part of a facility that has a different license must be handled the same way as a transfer to another facility and not as an intrafacility transfer. (II, III)
- [ARC 1752C, IAB 12/10/14, effective 1/14/15; ARC 3523C, IAB 12/20/17, effective 1/24/18]

**481—58.41(135C) Residents' rights.** Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

**58.41(1)** The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

**58.41(2)** The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

- a.* Designation of an employee responsible for handling grievances and recommendations. (II)
- b.* A method of investigating and assessing the validity of a grievance or recommendation. (II)
- c.* Methods of resolving grievances. (II)
- d.* Methods of recording grievances and actions taken. (II)

**58.41(3)** The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, and certified volunteer long-term care ombudsman and the text of Iowa Code section 135C.46 to provide to residents a further course of redress. (II)

[ARC 1205C, IAB 12/11/13, effective 1/15/14]

**481—58.42(135C) Financial affairs—management.** Each resident who has not been assigned a guardian or conservator by the court may manage the resident's own personal financial affairs, and

to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

**58.42(1)** The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

**58.42(2)** An employee shall be designated in writing to be responsible for resident accounts. (II)

**58.42(3)** The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or intellectually disabled resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

**58.42(4)** If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge that the resident has seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

**58.42(5)** A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

**58.42(6)** A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—58.43(135C) Resident abuse prohibited.** Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

**58.43(1)** Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

**58.43(2)** Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

**58.43(3)** Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff. (II)

**58.43(4)** Physicians' orders are required to utilize all types of physical restraints and shall be renewed at least quarterly. (II) Physical restraints are defined as the following:

Type I—the equipment used to promote the safety of the individual but is not applied directly to their person. Examples: divided doors and totally enclosed cribs.

Type II—the application of a device to the body to promote safety of the individual. Examples: vest devices, soft-tie devices, hand socks, geriatric chairs.

Type III—the application of a device to any part of the body which will inhibit the movement of that part of the body only. Examples: wrist, ankle or leg restraints and waist straps.

**58.43(5)** Physical restraints are not to be used to limit resident mobility for the convenience of staff and must comply with life safety requirements. If a resident's behavior is such that it may result in injury to the resident or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure(s) designed to modify the behavioral problems for which the resident is restrained, or as a last resort, after failure of attempted therapy. (I, II)

**58.43(6)** Each time a Type II or III restraint is used documentation on the nurse's progress record shall be made which includes type of restraint and reasons for the restraint and length of time resident was restrained. The documentation of the use of Type III restraint shall also include the time of position change. (II)

**58.43(7)** Each facility shall implement written policies and procedures governing the use of restraints which clearly delineate at least the following:

- a.* Physicians' orders shall indicate the specific reasons for the use of restraints. (II)
- b.* Their use is temporary and the resident will not be restrained for an indefinite amount of time. (I, II)
- c.* A qualified nurse shall make the decision for the use of a Type II or Type III restraint for which there shall be a physician's order. (II)
- d.* A resident placed in a Type II or III restraint shall be checked at least every 30 minutes by appropriately trained staff. No form of restraint shall be used or applied in such a manner as to cause injury or the potential for injury and provide a minimum of discomfort to resident restrained. (I, II)
- e.* Reorders are issued only after the attending physician reviews the resident's condition. (II)
- f.* Their use is not employed as punishment, for the convenience of the staff, or as a substitute for supervision or program. (I, II)
- g.* The opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which Type II and Type III restraints are employed, except when resident is sleeping. However, when resident awakens, this shall be provided. This shall be documented each time. A check sheet may serve this purpose. (I, II)
- h.* Locked restraints or leather restraints shall not be permitted except in life-threatening situations. Straight jackets and secluding residents behind locked doors shall not be employed. (I, II)
- i.* Nursing assessment of the resident's need for continued application of a Type III restraint shall be made every 12 hours and documented on the nurse's progress record. Documentation shall include the type of restraint, reason for the restraint and the circumstances. Nursing assessment of the resident's need for continued application of either a Type I or Type II restraint and nursing evaluation of the resident's physical and mental condition shall be made every 30 days and documented on the nurse's progress record. (II)
- j.* A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room. (II)
- k.* Divided doors shall be of the type that when the upper half is closed the lower section shall close. (II)
- l.* Methods of restraint shall permit rapid removal of the resident in the event of fire or other emergency. (I, II)
- m.* The facility shall provide orientation and ongoing education programs in the proper use of restraints.

**58.43(8)** In the case of an intellectually disabled individual who participates in a behavior modification program involving use of restraints or aversive stimuli, the program shall be conducted only with the informed consent of the individual's parent or responsible party. Where restraints are employed, an individualized program shall be developed by the interdisciplinary team with specific methodologies for monitoring its progress. (II)

*a.* The resident's responsible party shall receive a written account of the proposed plan of the use of restraints or aversive stimuli and have an opportunity to discuss the proposal with a representative(s) of the treatment team. (II)

*b.* The responsible party must consent in writing prior to the use of the procedure. Consent may also be withdrawn in writing. (II)

**58.43(9)** Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)

**58.43(10)** and **58.43(11)** Rescinded IAB 12/11/13, effective 1/15/14.

This rule is intended to implement Iowa Code sections 135C.14, 235B.3(1), and 235B.3(11).  
[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 1204C, IAB 12/11/13, effective 1/15/14]

**481—58.44(135C) Resident records.** Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

**58.44(1)** The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

**58.44(2)** Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

**58.44(3)** The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

**481—58.45(135C) Dignity preserved.** The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

**58.45(1)** Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

**58.45(2)** Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

**58.45(3)** Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

**58.45(4)** Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

**58.45(5)** Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply in emergency conditions. (II)

**481—58.46(135C) Resident work.** No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

**58.46(1)** Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

**58.46(2)** If the plan of care requires activities for therapeutic or training reasons, the plan for these activities shall be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time limited and reviewed at least quarterly. (II)

**58.46(3)** Residents who perform work for the facility must receive remuneration unless the work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

**481—58.47(135C) Communications.** Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

**58.47(1)** Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

**58.47(2)** Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

*a.* The resident refuses to see the visitor(s). (II)

*b.* The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)

*c.* The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

**58.47(3)** Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

**58.47(4)** Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

**58.47(5)** Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

**58.47(6)** Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

**58.47(7)** Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified intellectual disabilities professional or facility administrator for refusing permission. (II)

**58.47(8)** Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—58.48(135C) Resident activities.** Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified intellectual disabilities professional as appropriate in the resident's record. (II)

**58.48(1)** Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

**58.48(2)** All residents shall have the freedom to refuse to participate in these activities. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

**481—58.49(135C) Resident property.** Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

**58.49(1)** Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

**58.49(2)** Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

**58.49(3)** Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of the items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

**58.49(4)** A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

**58.49(5)** A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings

that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

**481—58.50(135C) Family visits.** Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room if available. (II)

**58.50(1)** The facility shall provide for needed privacy in visits between spouses. (II)

**58.50(2)** Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why an arrangement would have an adverse effect on the health of the resident. (II)

**58.50(3)** Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an agreement would have an adverse effect on the health of the resident. (II)

**481—58.51(135C) Choice of physician and pharmacy.** Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility.

A facility shall not require the repackaging of medications dispensed by the Veterans Administration or an institution operated by the Veterans Administration for the purpose of making the drug distribution system compatible with the system used by the facility. (II)

**481—58.52(135C) Incompetent resident.**

**58.52(1)** Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

**58.52(2)** The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

**481—58.53(135C) County care facilities.** In addition to Chapter 58 licensing rules, county care facilities licensed as nursing facilities must also comply with department of human services rules, 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

**481—58.54(73GA,ch 1016) Special unit or facility dedicated to the care of persons with chronic confusion or a dementing illness (CCDI unit or facility).**

**58.54(1)** A nursing facility which chooses to care for residents in a distinct part shall obtain a license for a CCDI unit or facility. In the case of a distinct part, this license will be in addition to its ICF license. The license shall state the number of beds in the unit or facility. (III)

*a.* Application for this category of care shall be submitted on a form provided by the department. (III)

*b.* Plans to modify the physical environment shall be submitted to the department. The plans shall be reviewed based on the requirements of 481—Chapter 61. (III)

**58.54(2)** A statement of philosophy shall be developed for each unit or facility which states the beliefs upon which decisions will be made regarding the CCDI unit or facility. Objectives shall be developed for each CCDI unit or facility as a whole. The objectives shall be stated in terms of expected results. (II, III)

**58.54(3)** A résumé of the program of care shall be submitted to the department for approval at least 60 days before a separate CCDI unit or facility is opened. A new résumé of the program of care shall be submitted when services are substantially changed. (II, III)

The résumé of the program of care shall:

- a. Describe the population to be served; (II, III)
- b. State philosophy and objectives; (II, III)
- c. List admission and discharge criteria; (II, III)
- d. Include a copy of the floor plan; (II, III)
- e. List the titles of policies and procedures developed for the unit or facility; (II, III)
- f. Propose a staffing pattern; (II, III)
- g. Set out a plan for specialized staff training; (II, III)
- h. State visitor, volunteer, and safety policies; (II, III)
- i. Describe programs for activities, social services and families; (II, III) and
- j. Describe the interdisciplinary care planning team. (II, III)

**58.54(4)** Separate written policies and procedures shall be implemented in each CCDI unit or facility.

There shall be:

a. Admission and discharge policies and procedures which state the criteria to be used to admit residents and the evaluation process which will be used. These policies shall require a statement from the attending physician agreeing to the placement before a resident can be moved into a CCDI unit or facility. (II, III)

b. Safety policies and procedures which state the actions to be taken by staff in the event of a fire, natural disaster, emergency medical or catastrophic event. Safety procedures shall also explain steps to be taken when a resident is discovered to be missing from the unit or facility and when hazardous cleaning materials or potentially dangerous mechanical equipment is being used in the unit or facility. The facility shall identify its method for security of the unit or facility and the manner in which the effectiveness of the security system will be monitored. (II, III)

c. Program and service policies and procedures which explain programs and services offered in the unit or facility including the rationale. (III)

d. Policies and procedures concerning staff which state minimum numbers, types and qualifications of staff in the unit or facility. (II, III)

e. Policies about visiting which suggest times and ensure the residents' rights to free access to visitors. (II, III)

f. Quality assurance policies and procedures which list the process and criteria which will be used to monitor and to respond to risks specific to the residents. This shall include, but not be limited to, drug use, restraint use, infections, incidents and acute behavioral events. (II, III)

**58.54(5)** Preadmission assessment of physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by a registered nurse and a staff social worker or social work consultant and shall become part of the permanent record upon admission of the resident. (II, III)

**58.54(6)** All staff working in a CCDI unit or facility shall have training appropriate to the needs of the residents. (II, III)

a. Upon assignment to the unit or facility, everyone working in the unit or facility shall be oriented to the needs of people with chronic confusion or dementing illnesses. They shall have special training appropriate to their job description within 30 days of assignment to the unit or facility. (II, III) The orientation shall be at least six hours. The following topics shall be covered:

- (1) Explanation of the disease or disorder; (II, III)
- (2) Symptoms and behaviors of memory-impaired people; (II, III)
- (3) Progression of the disease; (II, III)
- (4) Communication with CCDI residents; (II, III)
- (5) Adjustment to care facility residency by the CCDI unit or facility residents and their families; (II, III)
- (6) Inappropriate and problem behavior of CCDI unit or facility residents and how to deal with it; (II, III)
- (7) Activities of daily living for CCDI residents; (II, III)
- (8) Handling combative behavior; (II, III) and

(9) Stress reduction for staff and residents. (II, III)

*b.* Licensed nurses, certified aides, certified medication aides, social services personnel, housekeeping and activity personnel shall have a minimum of six hours of in-service training annually. This training shall be related to the needs of CCDI residents. The six-hour training shall count toward the required annual in-service training. (II, III)

**58.54(7)** There shall be at least one nursing staff person on a CCDI unit at all times. (I, II, III)

**58.54(8)** The CCDI unit or facility license may be revoked, suspended or denied pursuant to Iowa Code chapter 135C and Iowa Administrative Code 481—Chapter 50.

This rule is intended to implement 1990 Iowa Acts, chapter 1016.

**481—58.55(135C) Another business or activity in a facility.** A facility is allowed to have another business or activity in a health care facility or in the physical structure of the facility, if the other business or activity meets the requirements of applicable state and federal laws, administrative rules, and federal regulations.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “f” of subrule 58.55(1). (I, II, III)

**58.55(1)** The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a.* Health and safety risks for residents;
- b.* Noise created by the proposed business or activity;
- c.* Odors created by the proposed business or activity;
- d.* Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- e.* Proposed staffing for the business or activity; and
- f.* Sharing of services and staff between the proposed business or activity and the facility.

**58.55(2)** Approval of the state fire marshal shall be obtained before approval of the department will be considered.

**58.55(3)** A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 61. (I, II, III)

**481—58.56(135C) Respite care services.** Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A nursing facility which chooses to provide respite care services must meet the following requirements related to respite services and must be licensed as a nursing facility.

**58.56(1)** A nursing facility certified as a Medicaid nursing facility or Medicare skilled nursing facility must meet all Medicaid and Medicare requirements including CFR 483.12, admission, transfer and discharge rights.

**58.56(2)** A nursing facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

**58.56(3)** Rule 481—58.40(135C) regarding involuntary discharge or transfer rights, does not apply to residents who are being cared for under a respite care contract.

**58.56(4)** Pursuant to rule 481—58.13(135C), the facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements under 481—58.13(135C), except the requirements under subrule 58.13(7).

**58.56(5)** Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

**481—58.57(135C) Training of inspectors.**

**58.57(1)** Subject to the availability of funding, all nursing facility inspectors shall receive 12 hours of annual continuing education in gerontology, wound care, dementia, falls, or a combination of these subjects.

**58.57(2)** An inspector shall not be personally liable for financing the training required under subrule 58.57(1).

**58.57(3)** The department shall consult with the collective bargaining representative of the inspector in regard to the training required under this rule.

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.6(1), 135C.14, 135C.25, 135C.32, 135C.36 and 227.4 and 1990 Iowa Acts, chapter 1016.

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<sup>◇</sup> Two or more ARCs

<sup>1</sup> Effective date of 470—58.15(2) “c” delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86.  
 Effective date of 470—58.15(2) “c” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 6/4/86.

<sup>2</sup> See IAB, Inspections and Appeals Department.

## OBJECTION

At its February 13 meeting the Administrative Rules Review Committee voted the following objection: [Subrules 57.23(2) "b," 58.26(2) "b," 59.31(2) "b," 63.21(3) "b," published IAB 12/13/78]

The committee objects to the amendments to 470\* IAC 57.23(2) "b," 58.26(2) "b," 59.31(2) "b" and 63.21(3) "b," which strike the phrase "Twenty-five percent of the staffing may be provided by qualified volunteers. The time shall be spent in working with the organized program activity.", on the grounds these provisions are unreasonable. It is the understanding of the committee these deletions in effect require facilities to employ a person to coordinate recreation activities. It is the feeling of the committee this would result in higher per bed costs without demonstrably improving the services rendered to the patient. Volunteers have always played a major role in health care institutions, and no evidence has been submitted indicating a decline in that role or in public interest in donating time and energy.

These amendments appear in the 12-13-78 IAB, and have been filed under the emergency provisions of chapter 17A, 1979 Code.

\*Chapter 57 transferred to Inspections and Appeals[481], IAC 7/15/87.

CHAPTER 67  
GENERAL PROVISIONS FOR ELDER GROUP HOMES, ASSISTED LIVING PROGRAMS,  
AND ADULT DAY SERVICES

**481—67.1(231B,231C,231D) Definitions.** The following definitions apply to this chapter and to 481—Chapters 68, 69, and 70.

*“Activities of daily living”* means the following self-care tasks: bathing, dressing, grooming, eating, transferring, toileting, and ambulation.

*“Ambulatory”* or *“ambulation”* means physically and cognitively able to walk without aid of another person.

*“Applicable requirements”* means Iowa Code chapters 135C, 231B, 231C, 231D, 235B, 235E, and 562A, this chapter, and 481—Chapters 68, 69, and 70, as applicable, and includes any other applicable administrative rules and provisions of the Iowa Code.

*“Assignment”* means the distribution of work for which each staff member, regardless of certification or licensure status, is responsible during a given work period and includes a nurse directing an individual to do something the individual is already authorized to do.

*“Assistance”* means aid to a tenant who self-directs or participates in a task or activity or who retains the mental or physical ability, or both, to participate in a task or activity. Cueing of the tenant regarding a particular task or activity shall be construed to mean the tenant has participated in the task or activity.

*“Blueprint”* means copies of all completed drawings, schedules, and specifications that have been certified, sealed, and signed by an Iowa-licensed architect or Iowa-licensed engineer of record. The department may allow electronic transfer of blueprints pursuant to policy.

*“Certified staff”* means certified nursing assistants (CNAs) and certified medication assistants (CMAs) employed by the program.

*“Dementia”* means an illness characterized by multiple cognitive deficits which represent a decline from previous levels of functioning and includes memory impairment and one or more of the following cognitive disturbances: aphasia, apraxia, agnosia, and disturbance in executive functioning.

*“Department”* means the department of inspections and appeals.

*“Director”* means the director of the department of inspections and appeals.

*“Direct supervision”* means the provision of guidance and oversight of a delegated nursing task through the physical presence of the licensed nurse to observe and direct certified and noncertified staff.

*“Elope”* means that a tenant who has impaired decision-making ability leaves the program without the knowledge or authorization of staff.

*“Global Deterioration Scale”* or *“GDS”* means the seven-stage scale for assessment of primary degenerative dementia developed by Dr. Barry Reisberg.

*“Health care professional”* means a physician, physician assistant, registered nurse or advanced registered nurse practitioner licensed in Iowa by the respective licensing board.

*“Health-related care”* means services provided by a registered nurse or a licensed practical nurse, on a part-time or intermittent basis, and services provided by other licensed health care professionals, on a part-time or intermittent basis. “Health-related care” includes nurse-delegated assistance.

*“Human service professional”* means an individual with a bachelor’s degree in a human service field including, but not limited to: human services, gerontology, social work, sociology, psychology, or family science. Two years of experience in a human service field may be substituted for up to two years of the required education. For example, an individual with an associate’s degree in a human service field and two years of experience in a human service field is a human service professional.

*“Impaired decision-making ability”* means a lack of capacity to make safe and prudent decisions regarding one’s own routine safety as determined by the program manager or nurse or means having a GDS score of five or above.

*“Independent reviewer”* means an attorney licensed in the state of Iowa who is not currently and has not been employed by the department in the past eight years, or has not appeared in front of the department on behalf of a health care facility in the past eight years. Preference shall be given to an attorney with background knowledge, experience or training in long-term care.

*“Indirect supervision”* means the provision of guidance and oversight of a delegated nursing task through means other than direct supervision, including written and verbal communication.

*“Instrumental activities of daily living”* means those activities that reflect the tenant’s ability to perform household and other tasks necessary to meet the tenant’s needs within the community, which may include but are not limited to shopping, housekeeping, chores, and traveling within the community.

*“Medication setup”* means assistance with various steps of medication administration to support a tenant’s autonomy, which may include but is not limited to routine prompting, cueing and reminding, opening containers or packaging at the direction of the tenant, reading instructions or other label information, or transferring medications from the original containers into suitable medication dispensing containers, reminder containers, or medication cups.

*“Modification”* means any addition to or change in physical dimensions or structure, except as incidental to the customary maintenance of the physical structure of the program’s facility.

*“Monitoring”* means an on-site evaluation of a program, a complaint investigation, or a program-reported incident investigation performed by the department to determine compliance with applicable requirements. A monitor who performs a monitoring for the department shall be a registered nurse, human service professional, or another person with program-related expertise.

*“Noncertified staff”* means unlicensed and uncertified personnel employed by the program.

*“Nurse delegation”* means the action of a registered nurse, advanced registered nurse practitioner, or licensed practical nurse to direct competent certified and noncertified staff to perform selected nursing tasks in selected situations. The decision of a nurse to delegate is based on the delegation process, including assessment, planning, implementation, supervision, and evaluation of the tenant, nursing tasks, personnel, and the situation. The nurse, as a licensed professional, retains accountability for the delegation process and the decision to delegate. Licensed practical nurses may delegate within the scope of their license with the supervision of a registered nurse.

*“Occupancy agreement”* or *“contractual agreement”* means a written contract entered into between a program and a tenant that clearly describes the rights and responsibilities of the program and the tenant and other information required by applicable requirements. An occupancy agreement may include a separate signed lease and signed service agreement.

*“Part-time or intermittent care”* means licensed nursing services and professional therapies that are provided in combination with nurse-delegated assistance with medications or activities of daily living and do not exceed 28 hours per week or, for adult day services, 4 hours per day.

*“Personal care”* means assistance with the essential activities of daily living which may include but are not limited to transferring, bathing, personal hygiene, dressing, and grooming that are essential to the health and welfare of a tenant.

*“Physician extender”* means nurse practitioners, clinical nurse specialists, and physician assistants.

*“Preponderance of the evidence”* means that the evidence, considered and compared with the evidence opposed to it, produces the belief in a reasonable mind that the allegations are more likely true than not true.

*“Program”* means one or more of the following, as applicable: an elder group home as defined in Iowa Code section 231B.1 and 481—Chapter 68, an assisted living program as defined in Iowa Code section 231C.1 and 481—Chapter 69, or adult day services as defined in Iowa Code section 231D.1 and 481—Chapter 70.

*“Program staff”* means all employees of the program, regardless of certification or licensure status.

*“Qualified professional”* means a facility plant engineer familiar with the type of program being provided, or a licensed plumbing, heating, cooling, or electrical contractor who furnishes regular service to such equipment.

*“Recognized accrediting entity”* means a nationally recognized accrediting entity that the department recognizes as having specific program standards equivalent to the program standards established by the department.

*“Regulatory insufficiency”* means a violation of an applicable requirement.

*“Remodeling”* means a modification of any part of an existing building, an addition of a new wing or floor to an existing building, or a conversion of an existing building.

“*Restraints*” means any chemical or manual method which restricts freedom of movement or normal access to one’s body or any physical or mechanical device, material or equipment which is attached or adjacent to the tenant’s body that the tenant cannot remove easily and which restricts freedom of movement or normal access to one’s body.

“*Routine*” means more often than not or on a regular customary basis.

“*Self-administration*” means a tenant’s taking personal responsibility for all phases of medication except for any component assigned to the program under medication setup, and may include the tenant’s use of an automatic pill dispenser.

“*Service plan*” means the document that defines all services necessary to meet the needs and preferences of a tenant, whether or not the services are provided by the program or other service providers.

“*Significant change*” means a major decline or improvement in the tenant’s status which does not normally resolve itself without further interventions by staff or by implementing standard disease-related clinical interventions that have an impact on the tenant’s mental, physical, or functional health status.

“*Substantial compliance*” means a level of compliance with applicable requirements such that any identified regulatory insufficiency poses no greater risk to tenant health or safety than the potential for causing minimal harm.

“*Tenant*” means an individual who receives services through a program. In the context of adult day services, “tenant” means a participant as defined in 481—Chapter 70.

“*Tenant advocate*” means the office of long-term care resident’s advocate established in Iowa Code section 231.42.

“*Tenant’s legal representative*” means a person appointed by the court to act on behalf of a tenant or a person acting pursuant to a power of attorney. In the context of adult day services, “tenant’s legal representative” means a participant’s legal representative as defined in 481—Chapter 70.

“*Waiver*” means action taken by the department that suspends in whole or in part the requirements or provisions of a rule.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 1994C, IAB 5/27/15, effective 7/1/15; ARC 2463C, IAB 3/16/16, effective 4/20/16]

**481—67.2(231B,231C,231D) Program policies and procedures, including those for incident reports.** A program’s policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

**67.2(1)** The program’s policies and procedures on incident reports, at a minimum, shall include the following:

- a. The program shall have available incident report forms for use by program staff.
- b. An incident report shall be in detail and shall be provided on an incident report form.
- c. The person in charge at the time of the incident shall prepare and sign the report.
- d. The incident report shall include statements from individuals, if any, who witnessed the incident.
- e. All accidents or unusual occurrences within the program’s building or on the premises that affect tenants shall be reported as incidents.
- f. A copy of the completed incident report shall be kept on file on the program’s premises for a minimum of three years.

**67.2(2)** The program’s policies and procedures on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:

- a. Reporting requirements for staff and employees, and
- b. Requirements that the victim and alleged abuser be separated.

**67.2(3)** The program shall follow the policies and procedures established by the program.  
[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 4976C, IAB 3/11/20, effective 4/15/20]

**481—67.3(231B,231C,231D) Tenant rights.** All tenants have the following rights:

**67.3(1)** To be treated with consideration, respect, and full recognition of personal dignity and autonomy.

**67.3(2)** To receive care, treatment and services which are adequate and appropriate.

**67.3(3)** To receive respect and privacy in the tenant's medical care program. Personal and medical records shall be confidential, and the written consent of the tenant shall be obtained for the records' release to any individual, including family members, except as needed in case of the tenant's transfer to a health care facility or as required by law or a third-party payment contract.

**67.3(4)** To be free from mental and physical abuse.

**67.3(5)** To receive from the manager and staff of the program a reasonable response to all requests.

**67.3(6)** To associate and communicate privately and without restriction with persons and groups of the tenant's choice, including the tenant advocate, on the tenant's initiative or on the initiative of the persons or groups at any reasonable hour.

**67.3(7)** To manage the tenant's own financial affairs unless a tenant's legal representative has been appointed for the purpose of managing the tenant's financial affairs.

**67.3(8)** To present grievances and recommend changes in program policies and services, personally or through other persons or in combination with others, to the program's staff or person in charge without fear of reprisal, restraint, interference, coercion, or discrimination.

**67.3(9)** To be free from restraints.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

**481—67.4(231B,231C,231D) Program notification to the department.** The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:

**67.4(1)** Of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury.

*a.* "Major injury" shall be defined as any injury which:

- (1) Results in death; or
- (2) Requires admission to a higher level of care for treatment, other than for observation; or
- (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis.

*b.* The following are not reportable accidents:

- (1) An ambulatory tenant who falls when neither the program nor its employees have culpability related to the fall, even if the tenant sustains a major injury; or
- (2) Spontaneous fractures; or
- (3) Hairline fractures.

**67.4(2)** When damage to the program is caused by a natural or other disaster.

**67.4(3)** When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule, "pattern" means two or more times within a 30-day period.

**67.4(4)** When a tenant elopes from a program.

**67.4(5)** When a tenant attempts suicide, regardless of injury.

**67.4(6)** When a fire occurs in a program and the fire requires the notification of emergency services, requires full or partial evacuation of the program, or causes physical injury to a tenant.

**67.4(7)** When a defect or failure occurs in the fire sprinkler or fire alarm system for more than 4 hours in a 24-hour period. (This reporting requirement is in addition to the requirement to notify the state fire marshal.)

NOTE: Additional reporting requirements are created by other rules and statutes, including but not limited to Iowa Code chapters 235B and 235E, which require reporting of dependent adult abuse.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

**481—67.5(231B,231C,231D) Medications.**

**67.5(1)** If a program handles, stores, or administers controlled substances, the program shall be registered with the Iowa board of pharmacy as a care facility in accordance with 657—Chapter 10.

**67.5(2)** Each program shall follow its own written medication policy, which shall include the following:

- a. The program shall not prohibit a tenant from self-administering medications.
- b. A tenant shall self-administer medications unless:
  - (1) The tenant or the tenant's legal representative delegates in the occupancy agreement or signed service plan any portion of medication setup to the program.
  - (2) The tenant delegates medication setup to someone other than the program.
  - (3) The program assumes partial control of medication setup at the direction of the tenant. The medication plan shall not be implemented by the program unless the program's registered nurse deems it appropriate under applicable requirements, including those in Iowa Code section 231C.16A and subrule 67.9(4). The program's registered nurse must agree to the medication plan.
- c. A tenant shall keep medications in the tenant's possession unless the tenant or the tenant's legal representative, if applicable, delegates in the occupancy agreement or signed service plan partial or complete control of medications to the program. The service plan shall include the tenant's choice related to storage.
- d. When a tenant has delegated medication administration to the program, the program shall maintain a list of the tenant's medications. If the tenant self-administers medications, the tenant may choose to maintain a list of medications in the tenant's apartment or to disclose a current list of medications to the program for the purpose of emergency response. If the tenant discloses a medication list to the program in case of an emergency, the tenant remains responsible for the accuracy of the list.
- e. When medication setup is delegated to the program by the tenant, staff via nurse delegation may transfer medications from the original prescription containers or unit dosing into medication reminder boxes or medication cups.
- f. When medications are administered traditionally by the program:
  - (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645—Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA).
  - (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.
  - (3) The program shall maintain a list of each tenant's medications and document the medications administered.
  - (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.
- g. Narcotics protocol, including destruction and reconciliation, shall be determined by the program's registered nurse.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 1050C, IAB 10/2/13, effective 11/6/13; ARC 2463C, IAB 3/16/16, effective 4/20/16; ARC 4976C, IAB 3/11/20, effective 4/15/20]

**481—67.6(231B,231C,231D) Another business or activity located in a program.**

**67.6(1)** A business or activity serving persons other than tenants of a program is allowed in a designated part of the physical structure in which the program is located if the other business or activity meets the requirements of applicable state and federal codes, administrative rules, and federal regulations.

**67.6(2)** A business or activity conducted in the designated part of the physical structure in which the program is located shall not interfere with the use of the program by tenants or with services provided to tenants or disturb tenants.

**67.6(3)** A business or activity conducted in the designated part of the physical structure in which the program is located shall not reduce access, space, services, or staff available to tenants or necessary to meet the needs of tenants.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

**481—67.7(231B,231C,231D) Waiver of criteria for retention of a tenant in the program.**

**67.7(1) *Time-limited waiver.*** Upon receipt of a program's request for waiver of the criteria for retention of a tenant, the department may grant a waiver of the criteria under applicable requirements for a time-limited basis. Absent extenuating circumstances, a waiver of the criteria for retention of a tenant is limited to a period of six months or less.

**67.7(2) *Waiver petition procedures.*** The following procedures shall be used to request and to receive approval of a waiver from criteria for the retention of a tenant:

*a.* A program shall submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional.

*b.* The department shall respond in writing to a waiver request within 15 working days of receipt of all required documentation. In consultation with the program, the department may take an additional 15 working days to report its determination regarding the waiver request.

*c.* The program shall provide to the department within 5 working days written notification of any changes in the condition of the tenant as described in the approved waiver request.

**67.7(3) *Factors for consideration for waiver of criteria for retention of a tenant.*** In addition to the criteria established in Iowa Code subsection 17A.9A(2), the following factors may be demonstrative in determining whether the criteria for issuance of a waiver have been met.

*a.* It is the informed choice of the tenant or the tenant's legal representative, if applicable, to remain in the program;

*b.* The program is able to provide the staff necessary to meet the tenant's service needs in addition to the service needs of the other tenants;

*c.* The department shall only issue a waiver if the waiver will not jeopardize the health, safety, security or welfare of the tenant, program staff, or other tenants; and

*d.* The tenant has been diagnosed with a terminal illness and has been admitted to hospice, and the tenant exceeds the criteria for retention and admission for a temporary period of less than six months. A terminal diagnosis means the tenant is within six months of the end of life.

**67.7(4) *Conditional waiver.*** A conditional waiver may be granted contingent upon the department's receipt of additional information or performance of monitoring.

*a.* If a waiver has been in effect for six months, a monitoring shall be conducted to determine whether the tenant meets the criteria to continue on a waiver.

*b.* The department may seek additional information during the period to determine if a waiver should be granted.

**67.7(5) *Appeals.*** The denial of a waiver request may be appealed by the program pursuant to Iowa Code chapter 17A.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

**481—67.8(231B,231C,231D) All other waiver requests.** Waiver requests relating to topics other than retention of a tenant in a program shall be filed in accordance with 481—Chapter 6.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

**481—67.9(231B,231C,231D) Staffing.**

**67.9(1) *Number of staff.*** A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

**67.9(2) *Emergency procedures.*** All program staff shall be able to implement the accident, fire safety, and emergency procedures.

**67.9(3) Training documentation.** The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures.

**67.9(4) Nurse delegation procedures.** The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.

b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

c. Training for noncertified staff shall include, at a minimum, the provision of activities of daily living and instrumental activities of daily living.

d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

e. The program's registered nurse(s) shall provide direct or indirect supervision of all certified and noncertified staff as necessary in the professional judgment of the program's registered nurse and in accordance with the needs of the tenants and certified and noncertified staff.

f. Services shall be provided to tenants in accordance with the training provided.

g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request.

h. In the absence of the program's registered nurse due to vacation or other temporary circumstances, the nurse assuming the duties of the program's registered nurse shall have access to staff training in relation to tenant needs.

**67.9(5) Prohibited services.** A program staff member shall not be designated as attorney-in-fact, guardian, conservator, or representative payee for a tenant unless the program staff member is related to the tenant by blood, marriage, or adoption.

**67.9(6) Dependent adult abuse training.** Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 0963C, IAB 8/21/13, effective 9/25/13; ARC 2463C, IAB 3/16/16, effective 4/20/16]

#### **481—67.10(17A,231B,231C,231D) Monitoring.**

**67.10(1) Frequency of monitoring.** The department shall monitor a certified program at least once during the program's certification period.

**67.10(2) Accessibility of records and program areas.** All records and areas of the program deemed necessary to determine compliance with the applicable requirements shall be accessible to the department for purposes of monitoring.

**67.10(3) Standard for determining whether a regulatory insufficiency exists.** The department shall use a preponderance-of-the-evidence standard when determining whether a regulatory insufficiency exists. A preponderance-of-the-evidence standard does not require that the monitor shall have personally witnessed the alleged violation.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

#### **481—67.11(231B,231C,231D) Complaint and program-reported incident report investigation procedure.**

**67.11(1) Complaints.** The process for filing a complaint is as follows:

*a.* Any person with concerns regarding the operation or service delivery of a program may file a complaint with the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; by use of the complaint hotline, 1-877-686-0027; by facsimile sent to (515)281-7106; or through the website address: [dia-hfd.iowa.gov/DIA\\_HFD/Home.do](http://dia-hfd.iowa.gov/DIA_HFD/Home.do).

*b.* When the nature of the complaint is outside the department's authority, the department shall forward the complaint or refer the complainant, if known, to the appropriate investigatory entity.

*c.* The complainant shall include as much of the following information as possible in the complaint: the complainant's name, address and telephone number; the complainant's relationship to the program or tenant; and the reason for the complaint. The complainant's name shall be confidential information and shall not be released by the department. The department shall act on anonymous complaints unless the department determines that the complaint is intended to harass the program. If the department, upon preliminary review, determines that the complaint is intended as harassment or is without reasonable basis, the department may dismiss the complaint.

**67.11(2)** *Program-reported incident reports.* When the program is required pursuant to applicable requirements to report an incident, the program shall make the report to the department via:

*a.* The web-based reporting tool accessible from the following Internet site, [dia-hfd.iowa.gov/DIA\\_HFD/Home.do](http://dia-hfd.iowa.gov/DIA_HFD/Home.do), under the "Complaints" tab;

*b.* Mail by sending the complaint to the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083;

*c.* The complaint hotline, 1-877-686-0027; or

*d.* Facsimile sent to (515)281-7106.

**67.11(3)** *Time frames for investigation of complaints or program-reported incident reports.* Upon receipt of a complaint or program-reported incident report made in accordance with this rule, the department shall conduct a preliminary review of the complaint or report to determine if a potential regulatory insufficiency has occurred. If a potential regulatory insufficiency exists, the department shall institute a monitoring of the program within the following time frames: within 2 working days of receipt of the complaint or incident report if there is the possibility of immediate danger, including that the potential regulatory insufficiency has caused or is likely to cause serious injury, harm, impairment, or death to a resident; or within 20 working days of receipt of the complaint or incident report if the potential regulatory insufficiency has caused or may cause harm that negatively impacts a tenant's mental, physical, or psychosocial status or function and is of such consequence to the tenant's well-being that a rapid response is warranted; or within 45 working days of receipt of the complaint or incident report for any other complaint or incident investigation, including a potential regulatory insufficiency that may have caused harm of limited consequence and does not significantly impair the tenant's mental, physical, or psychosocial status or function.

**67.11(4)** *Standard for determining whether a complaint is substantiated.* The department shall apply a preponderance-of-the-evidence standard in determining whether or not a complaint or program-reported incident report is substantiated.

**67.11(5)** *Notification of program and complainant.* The department shall notify the program and, if known, the complainant of the final report regarding the complaint investigation.

**67.11(6)** *Notification of accrediting entity.* In addition, for any credible report of alleged improper or inappropriate conduct or conditions within an accredited program, the department shall notify the accrediting entity by the most expeditious means possible of any actions taken by the department with respect to certification enforcement.

**67.11(7)** *Notification of complainant when complaint not investigated.* The department shall notify the complainant, if known, if the department does not investigate a complaint. The reasons for not investigating the complaint shall be included in the notification.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 4976C, IAB 3/11/20, effective 4/15/20]

**481—67.12(17A,231B,231D) Adult day services and elder group homes—preliminary report, plan of correction and request for reconsideration.** Rescinded ARC 1701C, IAB 10/29/14, effective 1/1/15.

**481—67.13(17A,231B,231C,231D,85GA,HF2365) Exit interview, final report, plan of correction.**

**67.13(1) Exit interview.** The department shall provide an exit interview in person or by telephone at the conclusion of a monitoring, during which the department shall inform the program's representative of all issues and areas of concern related to insufficient practices. A second exit interview shall be provided if the department identifies additional issues or areas of concern. The program shall have 2 working days from the date of the exit interview to submit additional or rebuttal information to the department.

**67.13(2) Final report.** The department shall issue the final report of a monitoring within 10 working days after completion of the on-site monitoring or the receipt by the department of additional or rebuttal information, by personal service, electronically or by certified mail. The department shall issue a final report regarding a monitoring whether or not any regulatory insufficiency is found.

**67.13(3) Plan of correction.** Within 10 working days following receipt of the final report, the program shall submit a plan of correction to the department.

*a. Contents of plan.* The plan of correction shall include:

(1) Elements detailing how the program will correct each regulatory insufficiency, including at the system level;

(2) The date by which the regulatory insufficiency will be corrected;

(3) What measures will be taken to ensure the problem does not recur;

(4) How the program plans to monitor performance to ensure compliance; and

(5) Any other required information.

The date by which the regulatory insufficiency will be corrected shall not exceed 30 days from receipt of the final report pursuant to subrule 67.13(2) without approval of the department.

*b. Review of plan.* The department shall review the plan of correction within 10 working days. The department may request additional information or suggest revisions to the plan.

**67.13(4) Monitoring revisit.** The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 1701C, IAB 10/29/14, effective 1/1/15; ARC 4976C, IAB 3/11/20, effective 4/15/20]

**481—67.14(17A,231B,231C,231D,85GA,HF2365) Response to final report.** Within 20 working days after the issuance of the final report and assessment of civil penalty, if any, the program shall respond in the following manner.

**67.14(1) If not contesting final report.** If the program does not desire to seek an informal conference or contest the final report and civil penalty, if assessed, the program shall remit to the department of inspections and appeals the amount of the civil penalty, if assessed. If a program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if the requirements of subrule 67.17(5) are met.

**67.14(2) If contesting the final report.** If the program desires to contest the final report and civil penalty, if assessed, the program shall notify the department of inspections and appeals in writing that it desires to contest the final report and civil penalty and shall do one of the following:

*a.* Request an informal conference with an independent reviewer pursuant to subrule 67.14(3); or

*b.* Request a contested case hearing in the manner provided by Iowa Code chapter 17A for contested cases.

**67.14(3) Informal conference.**

*a. Request for informal conference.* The request for an informal conference must be in writing and include the following:

(1) Identification of the regulatory insufficiency(ies) being disputed;

- (2) The type of informal conference requested: face-to-face or telephone conference; and
- (3) A request for monitor's notes for the regulatory insufficiencies being disputed, if desired.

*b. Submission of documentation.* The program shall submit the following within 10 working days from the date of the program's written request for an informal conference:

- (1) The names of those who will be attending the informal conference, including legal counsel; and
- (2) Documentation supporting the program's position. The program must highlight or use some other means to identify written information pertinent to the disputed regulatory insufficiency(ies).

Supporting documentation that is not submitted with the request for an informal conference will not be considered, except as otherwise permitted by the independent reviewer upon good cause shown. "Good cause" means substantial or adequate grounds for failing to submit documentation in a timely manner. In determining whether the program has shown good cause, the independent reviewer shall consider what circumstances kept the program from submitting the supporting documentation within the required time frame.

*c. Face-to-face or telephone conference.* A face-to-face or telephone conference, if requested, will be scheduled to occur within 10 working days of the receipt of the written request, all supporting documentation and the plan of correction required by subrule 67.13(3).

- (1) Failure to submit supporting documentation will not delay scheduling.

(2) The conference will be scheduled for one hour. The program will informally present information and explanation concerning the contested regulatory insufficiency(ies). The department will have time to respond to the program's presentation. Due to the confidential nature of the conference, attendance may be limited.

(3) If additional information is requested by the independent reviewer during the informal conference, the program will have 2 working days to deliver the additional materials to the independent reviewer.

(4) When extenuating circumstances preclude a face-to-face conference, a telephone conference will be held or the program may be given one opportunity to reschedule the face-to-face conference.

*d. Results.* The results of the informal conference will generally be sent within 10 working days after the date of the informal conference, or within 10 working days after the receipt of additional information, if requested.

(1) The independent reviewer may affirm or may modify or dismiss the regulatory insufficiency and civil penalty. The independent reviewer shall state in writing the specific reasons for the affirmation, modification or dismissal of the regulatory insufficiency.

(2) The department will issue an amended (changes in factual content) or corrected (changes in typographical/data errors) final report if changes result from the informal conference.

(3) The program must submit to the department a new plan of correction for the amended or corrected report within 10 calendar days from the date of the letter conveying the results of the conference.

(4) If the informal conference results in dismissal of a regulatory insufficiency for which a civil penalty was assessed, the corresponding civil penalty will be rescinded.

**67.14(4) Procedure after informal conference.** After the conclusion of an informal conference:

*a.* If the program does not desire to further contest an affirmed or modified final report, the program shall, within 5 working days after receipt of the written decision of the independent reviewer, remit to the department of inspections and appeals the civil penalty, if assessed.

*b.* If the program does desire to further contest an affirmed or modified final report, the program shall, within 5 working days after receipt of the written decision of the independent reviewer, notify the department of inspections and appeals in writing that it desires to formally contest the final report.

**67.14(5) Contested case hearings.** Contested case hearings shall be conducted by the department's administrative hearings division pursuant to Iowa Code chapter 17A and 481—Chapter 9.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 1701C, IAB 10/29/14, effective 1/1/15; ARC 2142C, IAB 9/16/15, effective 10/21/15; ARC 3523C, IAB 12/20/17, effective 1/24/18]

**481—67.15(17A,231B,231C,231D) Denial, suspension or revocation of a certificate.**

**67.15(1) *Notice and request for hearing.*** The denial, suspension or revocation of a certificate shall be effected by delivering to the applicant or certificate holder by restricted certified mail or by personal service a notice setting forth the particular reasons for such actions. A denial, suspension or revocation shall be effective 30 days after certified mailing or personal service of the notice, unless the applicant or certificate holder gives the department written notice requesting a hearing within the 30-day period. If a timely request for hearing is made, the notice shall be deemed suspended pending the outcome of the hearing, unless subrule 67.15(3) or 67.15(4) applies. If an enforcement action has been implemented immediately in accordance with subrule 67.15(3) or 67.15(4), the enforcement action remains in effect regardless of a request for hearing.

**67.15(2) *Hearings.*** Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 9.

**67.15(3) *Immediate suspension of a certificate.*** When the department finds that an imminent danger to the health or safety of tenants of a program exists which requires action on an emergency basis, the department may direct removal of all tenants from the program and suspend the certificate or require additional remedies to ensure the ongoing safety of the program's tenants prior to a hearing.

**67.15(4) *Immediate imposition of enforcement action.*** When the department finds that an imminent danger to the health or safety of tenants exists which requires action on an emergency basis, the department may immediately impose a conditional certificate and accompanying conditions upon the program in lieu of immediate suspension of the certificate and removal of the tenants from the program if the department finds that tenants' health and safety would still be protected. The program may request a hearing, but the immediate enforcement action remains in effect regardless of the request for hearing. [ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 3523C, IAB 12/20/17, effective 1/24/18]

#### **481—67.16(17A,231B,231C,231D) Conditional certification.**

**67.16(1) *Conditional certification.*** In lieu of denial, suspension or revocation of a certificate, the department may issue a conditional certificate for a period of up to one year. Notwithstanding subrule 67.15(4), a conditional certificate shall be issued only when regulatory insufficiencies pose no greater risk to tenant health or safety than the potential for causing minimal harm.

*a.* The department shall specify the reasons for the conditional certificate in the notice issuing the conditional certificate.

*b.* The department may place conditions upon a certificate, such as requiring additional training; restriction of the program from accepting additional tenants for a period of time; or any other action or combination of actions deemed appropriate by the department.

*c.* Failure by the program to adhere to the plan of correction or conditions placed on the certificate may result in suspension or revocation of the conditional certification and may result in further enforcement action as available under applicable requirements.

*d.* A program must be in substantial compliance with applicable requirements before the removal of a conditional certificate by the department. Prior to lifting a conditional certificate, the department may conduct a monitoring to verify substantial compliance. Once the program is in substantial compliance with applicable requirements, the department shall lift the conditional certificate.

**67.16(2) *Appeal of conditional certificate.*** A written request for hearing must be received by the department within 30 days after the mailing or service of notice. The conditional certificate shall not be suspended pending the hearing. Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 9. [ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 3523C, IAB 12/20/17, effective 1/24/18]

#### **481—67.17(17A,231B,231C,231D) Civil penalties.**

**67.17(1) *When civil penalties may be issued.*** Civil penalties may be issued when the director finds that any of the following has occurred:

*a.* A program that does not comply with applicable requirements and the noncompliance results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than \$10,000.

*b.* A program that continues to fail or refuses to comply with applicable requirements within prescribed time frames established by the department or approved by the department in the program's plan of correction and the noncompliance has a direct relationship to the health, safety, or security of tenants may be assessed a civil penalty of not more than \$5,000.

*c.* A program that prevents, interferes with or attempts to impede in any way any duly authorized representative of the department in the lawful enforcement of applicable requirements may be assessed a civil penalty of not more than \$1,000.

*d.* A program that discriminates or retaliates in any way against a tenant, tenant's family, or an employee of the program who has initiated or participated in any proceeding authorized by Iowa Code chapter 231B, 231C or 231D and the corresponding administrative rules may be assessed a civil penalty of not more than \$5,000.

**67.17(2) Duplicate civil penalties prohibited.** The department shall not impose duplicate civil penalties on a program for the same set of facts and circumstances.

**67.17(3) Factors in determining the amount of a civil penalty.** The department shall consider the following factors when determining the amount of a civil penalty:

*a.* The frequency and length of time the regulatory insufficiency occurred (i.e., whether the regulatory insufficiency was an isolated or a widespread occurrence, practice, or condition);

*b.* The past history of the program as it relates to the nature of the regulatory insufficiency (the department shall not consider more than the current certification period and the immediately previous certification period);

*c.* The culpability of the program as it relates to the reasons the regulatory insufficiency occurred;

*d.* The extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;

*e.* The relationship of the regulatory insufficiency to any other types of regulatory insufficiencies which have occurred in the program;

*f.* The actions of the program after the occurrence of the regulatory insufficiency, including when corrective measures, if any, were implemented and whether the program notified the director as required;

*g.* The accuracy and extent of records kept by the program which relate to the regulatory insufficiency, and the availability of such records to the department;

*h.* The rights of tenants to make informed decisions;

*i.* Whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

**67.17(4) Civil penalties due.** The civil penalty shall be paid to the department within 30 days following the program's receipt of the final report and demand letter. The program may appeal in accordance with rule 481—67.14(17A,231C,85GA,SF394). If the program appeals, the civil penalty shall be deemed suspended until the appeal is resolved.

**67.17(5) Reduction of civil penalty amount by 35 percent.** If an assisted living program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if both of the following requirements are met:

*a.* The program does not request a formal hearing pursuant to rule 481—67.14(17A,231C,85GA,SF394), or withdraws its request for formal hearing within 30 calendar days of the date that the civil penalty was assessed; and

*b.* The civil penalty is paid and payment is received by the department within 30 calendar days of receipt of the final report.

[ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 4976C, IAB 3/11/20, effective 4/15/20]

**481—67.18(17A,231B,231C,231D) Judicial review.** Judicial review shall be conducted pursuant to Iowa Code chapter 17A and 481—Chapter 9.

[ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 3523C, IAB 12/20/17, effective 1/24/18]

**481—67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks.**

**67.19(1) Definitions.** The following definitions apply for the purposes of this rule.

“*Background check*” or “*record check*” means criminal history, child abuse and dependent adult abuse record checks.

“*Comprehensive preliminary background check*” means a criminal history check of all states in which the applicant has worked or resided over the seven-year period immediately prior to submitting an application for employment that is conducted by an approved third-party vendor.

“*Direct services*” means services provided through person-to-person contact. “Direct services” excludes services provided by individuals such as building contractors, repair workers, or others who are in a program for a very limited purpose, who are not in the program on a regular basis, and who do not provide any treatment or services for residents, patients, tenants, or participants of the provider.

“*Employed in a program*” or “*employment within a program*” means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An employee of an assisted living program certified under Iowa Code chapter 231C, if the employee provides direct services to consumers;
2. An employee of an elder group home certified under Iowa Code chapter 231B, if the employee provides direct services to consumers;
3. An employee of an adult day services program certified under Iowa Code chapter 231D, if the employee provides direct services to consumers.

“*Employee*” means any individual who is paid, either by the program or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors).

“*Evaluation*” means review by the department of human services to determine whether a founded child abuse, dependent adult abuse or criminal conviction warrants the person’s being prohibited from employment in a program.

“*Indirect services*” means services provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance.

“*Program,*” for purposes of this rule, means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An assisted living program certified under Iowa Code chapter 231C;
2. An elder group home certified under Iowa Code chapter 231B; and
3. An adult day services program certified under Iowa Code chapter 231D.

**67.19(2)** *Explanation of “crime.”* For purposes of this rule, the term “crime” does not include offenses under Iowa Code chapter 321 classified as simple misdemeanor or equivalent simple misdemeanor offenses from another jurisdiction.

**67.19(3)** *Requirements for employer prior to employing an individual.* Prior to employment of a person in a program, the program shall complete the background check requirements set forth below.

*a. Informing the prospective employee.* A program shall ask each person seeking employment by the program, “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime other than a simple misdemeanor offense relating to motor vehicles and laws of the road under Iowa Code chapter 321 or equivalent provisions in this state or any other state?” The person shall also be informed that a background check will be conducted. The person shall indicate, by signature, that the person has been informed that the background check will be conducted.

*b. Conducting a background check.* The program shall either request that the department of public safety perform a criminal history check and that the department of human services perform child and dependent adult abuse record checks of the person in this state, or access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person’s maiden name, if applicable, with the background check request.

*c. If a person considered for employment has been convicted of a crime.* If a person being considered for employment in a program has been convicted of a crime under a law of any state, the program shall request that the department of human services perform an evaluation to determine whether the crime warrants prohibition of the person’s employment in the program.

*d. If a person considered for employment has a record of founded child abuse or dependent adult abuse.* If a person being considered for employment in a program has a record of founded child or dependent adult abuse under the law of any state, the program shall request that the department of human

services perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program.

*e. Employment pending evaluation.* The program may provisionally employ a person prior to completion of the required record check and evaluation by the department of human services, as applicable, subject to all of the following:

(1) The program shall have accessed SING to perform the required record check and be awaiting results from SING or awaiting evaluation by the department of human services, as applicable;

(2) If applicable, the program shall request an evaluation by the department of human services in accordance with paragraph 67.19(3) “c” or “d” within 30 days of receipt of the SING record check results;

(3) The program shall have utilized an approved third-party vendor to perform a comprehensive preliminary background check;

(4) If the comprehensive preliminary background check determines that the person being considered for employment has been convicted of a crime, the crime does not constitute a felony as defined in Iowa Code section 701.7 and is not a crime specified pursuant to Iowa Code chapter 708, 708A, 709, 709A, 710, 710A, 711, or 712 or pursuant to Iowa Code section 726.3, 726.7, or 726.8;

(5) The comprehensive preliminary background check shall have determined that the person being considered for employment does not have a record of founded child abuse or dependent adult abuse, or, if the person being considered for employment does have a record of founded child abuse or dependent adult abuse, subrule 67.19(8) is applicable; and

(6) The provisional employment may continue until such time as the required record check through SING and evaluation by the department of human services, as applicable, are completed.

**67.19(4) Validity of background check results.** The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the program.

**67.19(5) Employment prohibition.** Except as provided in paragraph 67.19(3) “e,” a person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services.

**67.19(6) Transfer of an employee to another program owned or operated by the same person.** If an employee transfers from one program to another program owned or operated by the same person, without a lapse in employment, the program is not required to request additional criminal and child and dependent adult abuse record checks of that employee.

**67.19(7) Transfer of ownership of a program.** If the ownership of a program is transferred, at the time of transfer the background check required by this rule shall be performed for each employee for whom there is no documentation that such background check has been performed. The program may continue to employ such employee pending the performance of the background check and any related evaluation.

**67.19(8) Change of employment—person with criminal or abuse record—exception to record check evaluation requirements.** A person with a criminal or abuse record who is or was employed by a certified program and is hired by another certified program shall be subject to the background check.

*a.* A reevaluation of the latest record check is not required, and the person may commence employment with the other certified program if the following requirements are met:

(1) The department of human services previously performed an evaluation concerning the person’s criminal or abuse record and concluded the record did not warrant prohibition of the person’s employment;

(2) The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the prior evaluation;

(3) 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;

(4) Any restrictions placed on the person’s employment in the previous evaluation by the department of human services and still applicable shall remain applicable in the person’s subsequent employment; and

(5) The person subject to the background check has maintained a copy of the previous evaluation and provided it 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 current record check evaluation shall be performed.

*b.* For purposes of this subrule, a position is "substantially the same or has the same job responsibilities" if the position requires the same certification, licensure, or advanced training. For example, a licensed nurse has substantially the same or the same job responsibilities as a director of nursing; a certified nurse aide does not have substantially the same or the same job responsibilities as a licensed nurse.

*c.* The subsequent employer must maintain the previous evaluation in the employee's personnel file for verification of the exception to the requirement for a record check evaluation.

*d.* The subsequent employer may request a reevaluation of the background check and may employ the person while the reevaluation is being performed, even though an exemption under paragraph 67.19(8) "a" may be authorized.

**67.19(9)** *Employee notification of criminal convictions or founded abuse after employment.* If a person employed by an employer that is subject to this rule is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the employer of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

*a.* The employer shall act to verify the information within seven calendar days of notification. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

*b.* If the information is verified, the program shall follow the requirements of paragraphs 67.19(3) "c" and "d."

*c.* The employer may continue to employ the person pending the performance of an evaluation by the department of human services.

*d.* A person who is required by this subrule to inform the person's employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

*e.* The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under this subrule.

**67.19(10)** *Program receipt of credible information that an employee has been convicted of a crime or founded for abuse.* If the program receives credible information, as determined by the program, from someone other than the employee, that the employee has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment, and the employee has not informed the employer of the information within the time required by subrule 67.19(9), the program shall take the following actions:

*a.* The program shall act to verify credible information within seven calendar days of receipt. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

*b.* If the information is verified, the program shall follow the requirements of paragraphs 67.19(3) "c" and "d."

**67.19(11)** *Proof of background checks for temporary employment agencies and contractors.* Proof of background checks may be kept in the files maintained by temporary employment agencies and

contractors. Facilities may require temporary employment agencies and contractors to provide a copy of the result of the background checks. Copies of such results shall be made available to the department upon request.

This rule is intended to implement Iowa Code sections 231B.2(1), 231C.3(1), 231D.2(2), and 135C.33 and 2020 Iowa Acts, Senate File 2299.

[ARC 0963C, IAB 8/21/13, effective 9/25/13; ARC 1547C, IAB 7/23/14, effective 8/27/14; ARC 5421C, IAB 2/10/21, effective 3/17/21]

**481—67.20(17A,231C,231D) Emergency removal of tenants.** If the department determines that the health or safety of tenants is in jeopardy and the tenants need to be removed from the program, the department shall use the following procedures to ensure a safe and orderly transfer.

**67.20(1)** The department shall notify the department of human services, the tenant advocate, the appropriate area agency on aging, and other agencies as necessary and appropriate:

- a. To alert them to the need to transfer tenants from a program;
- b. To request assistance in identifying alternative programs or other appropriate settings; and
- c. To contact the tenants and their legal representatives or family members, if applicable, and others as appropriate, including health care professionals.

**67.20(2)** The department shall notify the program of the immediate need to transfer tenants and of any assistance available, in coordination with the appropriate parties under subrule 67.20(1).

**67.20(3)** The department, in conjunction with other agencies as necessary and appropriate, shall proceed with the transfer of tenants.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.21(231C) Nursing assistant work credit.**

**67.21(1)** A person who is certified as a nursing assistant, including a medication aide, and who is supervised by a registered nurse may submit information to the department to obtain credit toward maintaining certification for working in a program. A program may add an employee to the direct care worker registry by calling (515)281-4077 or by registering through the health facilities division website at [dia-hfd.iowa.gov/DIA\\_HFD/Home.do](http://dia-hfd.iowa.gov/DIA_HFD/Home.do), under the “Documents” tab.

**67.21(2)** A program shall complete and submit to the department a direct care worker registry application for each certified nursing assistant who works in the program. A registered nurse employed by the program shall supervise the nursing assistant. The application may be obtained by telephone at (515)281-4077 or via the health facilities division website at [dia-hfd.iowa.gov/DIA\\_HFD/Home.do](http://dia-hfd.iowa.gov/DIA_HFD/Home.do), under the “Documents” tab.

**67.21(3)** A program shall complete and submit to the department a direct care worker registry quarterly employment report whenever a change in the employment of a certified nursing assistant occurs. The report form may be obtained by telephone at (515)281-4077 or via the health facilities division website at [dia-hfd.iowa.gov/DIA\\_HFD/Home.do](http://dia-hfd.iowa.gov/DIA_HFD/Home.do), under the “Documents” tab.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

**481—67.22(231B,231C,231D) Public or confidential information.**

**67.22(1) Public information.**

a. *Public disclosure of findings.* The program shall post a notice stating that copies of the final report resulting from a monitoring are available via the department’s website at [dia-hfd.iowa.gov/DIA\\_HFD/Home.do](http://dia-hfd.iowa.gov/DIA_HFD/Home.do). The program shall post the notice in a prominent location on the premises of the program. Copies shall also be available upon request from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0083; telephone (515)281-6325.

b. *Open records.* The following records are open records available for inspection:

- (1) Certification applications, certification status, and accompanying materials;
- (2) Final findings of state monitorings, including a monitoring that results from a complaint or program-reported incident;
- (3) Reports from the state fire marshal;

- (4) Plans of correction submitted by a program;
- (5) Official notices of certification sanctions, including enforcement actions;
- (6) Findings of fact, conclusions of law, decisions and orders issued pursuant to rules 481—67.10(17A,231B,231C,231D) and 481—67.13(17A,231B, 231C,231D);
- (7) Waivers, including the department’s approval and denial letter and any letter requesting the waiver.

**67.22(2) Confidential information.** Confidential information includes the following:

- a. Information that does not comprise a final report resulting from a monitoring, complaint investigation, or program-reported incident investigation. Information which does not comprise a final report may be made public in a legal proceeding concerning a denial, suspension or revocation of certification;
- b. Names of all complainants;
- c. Names of tenants of a program, identifying medical information, copies of documentation appointing a legal representative, and the address of anyone other than an owner or operator; and
- d. Social security numbers or employer identification numbers (EIN).

**67.22(3) Redaction of confidential information.** If a record normally open for inspection contains confidential information, the confidential information shall be redacted before the records are provided for inspection.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 4976C, IAB 3/11/20, effective 4/15/20]

**481—67.23(231B,231C,231D) Training related to Alzheimer’s disease and similar forms of irreversible dementia.** Rescinded ARC 1547C, IAB 7/23/14, effective 8/27/14.

These rules are intended to implement Iowa Code chapters 231B, 231C as amended by 2013 Iowa Acts, Senate File 394, and 231D.

- [Filed ARC 8174B (Notice ARC 7877B, IAB 6/17/09), IAB 9/23/09, effective 1/1/10]
- [Filed ARC 0961C (Notice ARC 0809C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]
- [Filed ARC 0963C (Notice ARC 0808C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]
- [Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]
- [Filed ARC 1055C (Notice ARC 0941C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]
- [Filed ARC 1547C (Notice ARC 1472C, IAB 5/28/14), IAB 7/23/14, effective 8/27/14]
- [Filed ARC 1701C (Notice ARC 1616C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1994C (Notice ARC 1942C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]
- [Filed ARC 2142C (Notice ARC 2067C, IAB 7/22/15), IAB 9/16/15, effective 10/21/15]
- [Filed ARC 2463C (Notice ARC 2200C, IAB 10/14/15), IAB 3/16/16, effective 4/20/16]
- [Filed ARC 3523C (Notice ARC 3407C, IAB 10/25/17), IAB 12/20/17, effective 1/24/18]
- [Filed ARC 4976C (Notice ARC 4867C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]
- [Filed ARC 5421C (Notice ARC 5335C, IAB 12/16/20), IAB 2/10/21, effective 3/17/21]



## **RACING AND GAMING COMMISSION[491]**

[Prior to 11/19/86, Chs 1 to 10, see Racing Commission[693]; Renamed Racing and Gaming

Division [195] under the “umbrella” of Commerce, Department of [181], 11/19/86]

[Prior to 12/17/86, Chs 20 to 25, see Revenue Department[730] Chs 91 to 96]

[Transferred from Commerce Department[181] to the Department of Inspections and Appeals “umbrella”[481]  
pursuant to 1987 Iowa Acts, chapter 234, section 421]

[Renamed Racing and Gaming Commission[491], 8/23/89; See 1989 Iowa Acts, ch 67 §1(2), and ch 231 §30(1), 31]

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CHAPTER 1  
ORGANIZATION AND OPERATION

[Prior to 11/19/86, Racing Commission[693]]

[Prior to 11/18/87, Racing and Gaming Division[195]]

[Prior to 8/9/00, see also 491—Chs 6, 20 and 21]

**491—1.1(99D,99E,99F) Function.** The racing and gaming commission was created by Iowa Code chapter 99D and is charged with the administration of the Iowa pari-mutuel wagering Act and excursion boat gambling Act, sports wagering, and internet fantasy sports contests. Iowa Code chapters 99D, 99E and 99F mandate that the commission shall have full jurisdiction over and shall supervise all race meetings, gambling operations, sports wagering, and internet fantasy sports contests governed by Iowa Code chapters 99D, 99E and 99F.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—1.2(99D,99F) Organization, meetings, and procedure.**

**1.2(1) Organization.**

*a.* The racing and gaming commission is located at 1300 Des Moines Street, Suite 100, Des Moines, Iowa 50309; telephone (515)281-7352. Office hours are 8 a.m. to 4:30 p.m., Monday through Friday.

*b.* The racing and gaming commission consists of five members. The membership shall elect a chairperson and vice-chairperson in July of each year. No chairperson shall serve more than four consecutive one-year full terms.

**1.2(2) Meetings.**

*a.* The commission meets periodically throughout the year and shall meet in July of each year. Notice of a meeting is published on the commission's Web site at <https://irgc.iowa.gov/> at least five days in advance of the meeting or will be sent to interested persons upon request. The notice shall contain the specific date, time, and place of the meeting. Agendas are available to any interested persons not less than five days in advance of the meeting.

*b.* Persons wishing to appear before the commission should submit a written request to the commission office not less than ten working days prior to the meeting. The administrator or commission may place a time limit on presentations after taking into consideration the number of presentations requested.

*c.* Special or electronic meetings may be called by the chairperson only upon a finding of good cause and shall be held in strict accordance with Iowa Code section 21.4 or 21.8.

**1.2(3) Procedure.** All meetings shall be open to the public unless a closed session is voted by four members or all members present for the reasons specified in Iowa Code section 21.5. The operation of commission meetings shall be governed by the following rules of procedure:

*a.* A quorum shall consist of three members.

*b.* When a quorum is present, a position is carried by an affirmative vote of the majority of the entire membership of the commission.

*c.* A commissioner, who is present at a meeting of the commission when action is taken, shall be presumed to have assented to the action unless the commissioner's dissent was requested to be entered in the minutes. A roll-call vote on any motion may be recorded in the minutes. Reconsideration of any action may only be initiated by a commissioner who voted with the prevailing side. The motion to reconsider any action may be made and seconded before the conclusion of the meeting when the action was approved, or it may be made in writing and submitted to the commission office within two business days following the meeting. Only the mover has the option to request that the motion be held in abeyance, when the motion to reconsider is offered during the same meeting. Any commissioner is eligible to call up the motion to reconsider at the next meeting of the commission. The official minutes shall record the offering of any motion to reconsider, whether placed during the meeting or by timely written submission.

*d.* The presiding officer may exclude any person from the meeting for behavior that disrupts or obstructs the meeting.

*e.* Cases not covered by this rule shall be governed by the most recent edition of Robert's Rules of Order Newly Revised.

[ARC 0734C, IAB 5/15/13, effective 6/19/13; ARC 1506C, IAB 6/25/14, effective 7/30/14; ARC 2927C, IAB 2/1/17, effective 3/8/17]

**491—1.3(99D,99F) Administration of the commission.** The commission shall appoint an administrator for the racing and gaming commission who is responsible for the day-to-day administration of the commission's activities.

**491—1.4(17A,22,99D,99F) Open records.** Except as provided in Iowa Code sections 17A.2(11) "f," 22.7, 99D.7(8), and 99F.4(6), all public records of the commission shall be available for public inspection during business hours. Requests to obtain records may be made by mail, telephone, or fax or in person. Minutes of commission meetings, forms, and other records routinely requested by the public may be obtained without charge or viewed on the commission's Web site. Other records requiring more than ten copies may be obtained upon payment of the actual cost for copying. This charge may be waived by the administrator.

**491—1.5(17A,99D,99F) Forms.** All forms utilized in the conduct of business with the racing and gaming commission shall be available from the commission upon request. These forms include but are not limited to:

**1.5(1) Racing, gambling structure, or excursion gambling boat license application.** This form shall contain at a minimum the full name of the applicant, all ownership interests, balance sheets and profit-and-loss statements for three fiscal years immediately preceding the application, pending legal action, location and physical plant of the facility, and description of proposed operation. The form may include other information the commission deems necessary to make a decision on the license application. The qualified nonprofit corporation and the boat operator, if different than the qualified nonprofit corporation, shall pay a nonrefundable application fee in the amount of \$25,000 to offset the commission's cost for processing the application. Additionally, the applicant shall remit an investigative fee of \$30,000 to the department of public safety to do background investigations as required by the commission. The department of public safety shall bill the applicant/licensee for additional fees as appropriate and refund any unused portion of the investigative fee within 90 days after the denial or operation begins.

**1.5(2) Renewal application for racing license.** This form shall contain, at a minimum, the full name of the applicant, racing dates, simulcast proposal, feasibility of racing facility, distribution to qualified sponsoring organizations, table of organization, management agreement, articles of incorporation and bylaws, lease agreements, financial statements, information on the gambling treatment program, and description of racetrack operations. The form may include other information the commission deems necessary to make a decision on the license application.

**1.5(3) Renewal application for excursion gambling boat or gambling structure license.** This form shall contain, at a minimum, the full name of the applicant, annual fee, distribution to qualified sponsoring organizations, table of organization, internal controls, operating agreement, hours of operation, casino operations, Iowa resources, contracts, guarantee bond, notarized certification of truthfulness, and gambling treatment program. The form may include other information the commission deems necessary to make a decision on the license application. An annual fee to operate an excursion gambling boat shall be based on the passenger-carrying capacity including crew. For a gambling structure, the annual license fee shall be based on the capacity of the gambling structure. The fee shall be \$5 per person capacity and accompany this application.

**1.5(4) Renewal application for racetrack enclosure license.** This form shall contain, at a minimum, the full name of the applicant, annual fee, casino operations, internal controls, Iowa resources, guarantee bond, and notarized certification of truthfulness. The form may include other information the commission deems necessary to make a decision on the license application. A \$1,000 application fee must accompany this license application.

**1.5(5) Occupational license application.** This form shall contain, at a minimum, the applicant's full name, social security number, residence, date of birth, and other personal identifying information that the commission deems necessary. A fee set by the commission shall apply to this application. (Refer to 491—Chapter 6 for additional information.)

**1.5(6) Season approvals.** This form shall contain, at a minimum, a listing of the department heads and racing officials, minimum purse, purse supplements for Iowa-breds, grading system (greyhound racing only), schedule and wagering format, equipment, security plan, certification, and any other information the commission deems necessary for approval. This request must be submitted 45 days prior to the meet. Any changes to the items approved by the commission shall be requested in writing by the licensee and subject to the written approval of the administrator or commission representative before the change occurs.

**1.5(7) Manufacturers and distributors license application.** This form shall contain at a minimum the full name of the applicant, all ownership interests, balance sheets and profit-and-loss statements for three fiscal years immediately preceding the application, pending legal action, location and physical plant of the applicant, and description of proposed operation. The form may include other information the administrator deems necessary to make a decision on the license application. A license fee of \$1,000 for a distributor's license and a license fee of \$250 for a manufacturer's license shall accompany this application. (Refer to 491—Chapter 11 for additional information.)

**1.5(8) Advance deposit wagering license application.** This form shall contain at a minimum the full name of the applicant, all ownership interests, balance sheets and profit-and-loss statements for three fiscal years immediately preceding the application, pending legal action, location and physical plant of the applicant, and description of proposed operation. The form may include other information the administrator deems necessary to make a decision on the license application. A license fee of \$1,000 shall accompany this application. (Refer to 491—Chapter 8 for additional information.)

**1.5(9) Asset/stock purchase form for commission approval.** This form shall contain at a minimum the full name of the applicant, all ownership interests, balance sheets and profit-and-loss statements for three fiscal years immediately preceding the application, pending legal action, location and physical plant of the applicant, and description of proposed operation. The form may include other information the administrator deems necessary to make a decision.

**1.5(10) Sports wagering for excursion gambling boat, gambling structure or racetrack enclosure application.** This form shall contain, at a minimum, the full name of the applicant, disclosure of agreements involving sports wagering, a guarantee bond in an amount as determined by the commission, and a notarized certification of truthfulness. The applicant shall pay a nonrefundable application fee in the amount of \$45,000 to the commission.

**1.5(11) Renewal application for sports wagering for excursion gambling boat, gambling structure or racetrack enclosure.** This form shall contain, at a minimum, the full name of the applicant, a \$10,000 annual fee, disclosure of agreements involving sports wagering, sports wagering operations, internal controls, a guarantee bond in an amount as determined by the commission, a gambling treatment program, and a notarized certification of truthfulness. The form may include other information the commission deems necessary to make a decision on the license application.

**1.5(12) Advance deposit sports wagering operator application.** This form shall contain, at a minimum, the full name of the applicant, all ownership interests, balance sheets and profit-and-loss statements for three fiscal years immediately preceding the application, pending legal action, agreement with licensed facility or description of proposed operation, a gambling treatment program, and a notarized certification of truthfulness. The form may include other information the commission deems necessary to make a decision on the license application.

**1.5(13) Internet fantasy sports contest application.** This form shall contain, at a minimum, the full name of the applicant, board members, all ownership interests, balance sheets and profit-and-loss statements for the fiscal year immediately preceding the application, pending legal action, proof of satisfactory segregation of internet fantasy sports contest player contest funds as determined by the commission, a description of the proposed operation and a notarized certification of truthfulness. The

form may include other information the commission deems necessary to make a decision on the license application.

[ARC 1506C, IAB 6/25/14, effective 7/30/14; ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—1.6(99D,99F) Limitation on location and number of racetracks and excursion gambling boats.** Rescinded IAB 9/29/04, effective 11/3/04.

**491—1.7(99D,99F) Criteria for granting licenses, renewing licenses, and determining race dates.** The commission sets forth the following criteria which the commission will consider when deciding whether to issue a license to conduct racing or gaming or sports wagering in Iowa. The various criteria may not have the same importance in each instance, and other factors may present themselves in the consideration of an application for a license. The criteria are not listed in order of priority. After the initial consideration for issuing a license, applicable criteria need only be considered when an applicant has demonstrated a deficiency.

**1.7(1) Compliance.** The commission will consider whether or not the applicant is and has been in compliance with the terms and conditions specified in Iowa Code section 99D.9 or 99F.4. The commission will also consider whether the proposed facility is in compliance with applicable state and local laws regarding fire, health, construction, zoning, and other similar matters.

**1.7(2) Gaming integrity.** The commission will consider whether the proposed operation would ensure that gaming and sports wagering are conducted with a high degree of integrity in Iowa and that the officers, directors, partners, or shareholders of the operation are of good repute and moral character. The commission shall decide what weight and effect evidence about an officer, director, partner, or shareholder should have in the determination of whether there is substantial evidence that the individual is not of good reputation and character. For the purposes of this chapter, the term “directors” shall also include managers of limited liability companies and the term “shareholders” shall also include members of limited liability companies.

**1.7(3) Economic impact and development.** The commission will consider:

*a.* The amount of revenue to be provided by the proposed facility to the state and local communities through direct taxation on the facility’s operation and indirect revenues from tourism, ancillary businesses, creation of new industry, and taxes on employees and patrons. The commission may engage an independent firm proficient in market feasibility studies in the industry for specific analysis of any application to determine the potential market of any proposed facility as well as the impact on existing licensees.

*b.* The level of financial and other support the proposed operation will provide to the community in order to improve the quality of life of the residents of the community.

*c.* The viability and overall net benefit of the proposed operation to the state gaming industry, taking into consideration:

(1) Investment versus projected adjusted gross revenue.

(2) Impact on existing operators’ adjusted gross revenue versus existing operators’ ratio of adjusted gross revenue to investment.

(3) Ratio of equity to total investment and whether the proposed project is adequately and properly financed.

(4) Percent of projected adjusted gross revenue from underserved markets.

(5) Percent of projected adjusted gross revenue from existing Iowa operators.

(6) Stability and reliability of out-of-state market(s).

*d.* The benefits to Iowa tourism.

*e.* The number and quality of employment opportunities for Iowans.

*f.* The development and sale of Iowa products.

*g.* The number and types of developments and amenities associated with the proposed operation in addition to the gaming floor.

**1.7(4) Efficient and safe operation.** The commission will consider whether the proposed facility is planned in a manner that promotes efficient and safe operation of all aspects of the facility including

providing adequate security for employees and patrons. Adequate employment to serve patrons' needs, facility scope and design, parking facilities, access to cashier windows, concessions, and restrooms will be considered.

**1.7(5) *Community support.*** The commission will consider support for the proposed project within the community in which a proposed facility is to be located.

**1.7(6) *Nurture of the racing industry.*** The commission will consider whether the proposed racetrack operation would serve to nurture, promote, develop, and improve the racing industry in Iowa and provide high-quality racing in Iowa. The commission will also consider if the proposed racetrack operation will maximize purses and is beneficial to Iowa breeders.

**1.7(7) *Other factors.*** The commission will consider such other factors as may arise in the circumstances presented by a particular application.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—1.8(17A,99D,99F) Granting of a waiver.** For purposes of this rule, a waiver means action by the commission that suspends in whole or in part the requirements or provisions of a rule as applied to an identified entity on the basis of the particular circumstances of that entity.

**1.8(1) *Scope of rule.*** This rule outlines generally applicable standards and a uniform process for the granting of a waiver from rules adopted by the commission in situations where no other more specifically applicable law provides for waivers. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede this rule with respect to any waiver from that rule.

**1.8(2) *Applicability of rule.*** The commission may grant a waiver from a rule only if the commission has jurisdiction over the rule and the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law. The commission may not waive requirements created or duties imposed by statute.

**1.8(3) *Criteria for waiver.*** In response to a petition completed pursuant to subrule 1.8(5), the commission may in its sole discretion issue an order waiving in whole or in part the requirements of a rule if the commission finds, based on clear and convincing evidence, all of the following:

*a.* The application of the rule would impose an undue hardship on the entity for whom the waiver is requested;

*b.* The waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any entity;

*c.* The provisions of the rule subject to the petition for a waiver are not specifically mandated by statute or another provision of law; and

*d.* Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

**1.8(4) *Filing of petition.*** A petition for a waiver must be submitted in writing to the commission as follows:

*a. License application.* If the petition relates to a license application, the petition shall be made in accordance with the filing requirements for the license in question.

*b. Contested cases.* If the petition relates to a pending contested case, the petition shall be filed in the contested case proceeding, using the caption of the contested case.

*c. Other.* If the petition does not relate to a license application or a pending contested case, the petition may be submitted to the administrator.

**1.8(5) *Content of petition.*** A petition for waiver shall include the following information where applicable and known to the requester:

*a.* The name, address, and telephone number of the person or entity for whom a waiver is being requested, and the case number of any related contested case.

*b.* A description and citation of the specific rule from which a waiver is requested.

*c.* The specific waiver requested, including the precise scope and duration.

*d.* The relevant facts that the petitioner believes would justify a waiver under each of the four criteria described in subrule 1.8(3). This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition, and a statement of reasons that the petitioner believes will justify a waiver.

*e.* A history of any prior contacts between the commission and the petitioner relating to the regulated activity or license affected by the proposed waiver, including a description of each affected license held by the requester, any notices of violation, contested case hearings, or investigative reports relating to the regulated activity or license within the last five years.

*f.* Any information known to the requester regarding the commission's treatment of similar cases.

*g.* The name, address, and telephone number of any public agency or political subdivision which also regulates the activity in question, or which might be affected by the grant of a waiver.

*h.* The name, address, and telephone number of any person or entity who would be adversely affected by the grant of a waiver.

*i.* The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

*j.* Signed releases of information authorizing persons with knowledge regarding the request to furnish the commission with information relevant to the waiver.

**1.8(6) Additional information.** Prior to issuing an order granting or denying a waiver, the commission may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the commission may, on its own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the administrator, a committee of the commission, or a quorum of the commission.

**1.8(7) Notice.** The commission shall acknowledge a petition upon receipt. The commission shall ensure that notice of the pendency of the petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law, within 30 days of the receipt of the petition. In addition, the commission may give notice to other persons.

To accomplish this notice provision, the commission may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law, and provide a written statement to the commission attesting that notice has been provided.

**1.8(8) Hearing procedures.** The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply to any petition for a waiver filed within a contested case and shall otherwise apply to agency proceedings for a waiver only when the commission so provides by rule or order or is required to do so by statute.

**1.8(9) Ruling.** An order granting or denying a waiver shall be in writing and shall contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts, reasons upon which the action is based, and a description of the precise scope and duration of the waiver if one is issued.

**1.8(10) Board discretion.** The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the commission, upon consideration of all relevant factors. Each petition for a waiver shall be evaluated by the commission based on the unique, individual circumstances set out in the petition.

**1.8(11) Burden of persuasion.** The burden of persuasion rests with the petitioner to demonstrate by clear and convincing evidence that the commission should exercise its discretion to grant a waiver from a commission rule.

**1.8(12) Narrowly tailored exception.** A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

**1.8(13) Administrative deadlines.** When the rule from which a waiver is sought establishes administrative deadlines, the commission shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

**1.8(14) Conditions.** The commission may place any condition on a waiver that the commission finds desirable to protect the public health, safety, and welfare.

**1.8(15) *Time period of waiver.*** A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the commission, a waiver may be renewed if the commission finds that grounds for the waiver continue to exist.

**1.8(16) *Time for ruling.*** The commission shall grant or deny a petition for a waiver as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the commission shall grant or deny the petition no later than the time at which the final decision in that contested case is issued.

**1.8(17) *When deemed denied.*** Failure of the commission to grant or deny a petition within the required time period shall be deemed a denial of that petition by the commission. However, the commission shall remain responsible for issuing an order denying a waiver.

**1.8(18) *Service of order.*** Within seven days of its issuance, any order issued under this rule shall be transmitted to the petitioner or the person to whom the order pertains and to any other person entitled to such notice by any provision of law.

**1.8(19) *Public availability.*** All orders granting or denying a waiver petition shall be indexed, filed, and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver and orders granting or denying a waiver petition are public records under Iowa Code chapter 22. Some petitions or orders may contain information the commission is authorized or required to keep confidential. The commission may accordingly redact confidential information from petitions or orders prior to public inspection.

**1.8(20) *Submission of waiver information.*** All orders granting or denying a waiver petition shall be submitted to the legislative services agency through the Internet site established pursuant to Iowa Code section 17A.9A for such submissions within 60 days of the granting or denial of the petition.

**1.8(21) *Summary reports.*** Semiannually, the commission shall prepare a summary report identifying the rules for which a waiver has been granted or denied, the number of times a waiver was granted or denied for each rule, a citation to the statutory provisions implemented by these rules, and a general summary of the reasons justifying the commission's actions on waiver requests. If practicable, the report shall detail the extent to which the granting of a waiver has affected the general applicability of the rule itself. Copies of this report shall be available for public inspection and shall be provided semiannually to the administrative rules coordinator and the administrative rules review committee.

**1.8(22) *Cancellation of a waiver.*** A waiver issued by the commission pursuant to this rule may be withdrawn, canceled, or modified if, after appropriate notice and hearing, the commission issues an order finding any of the following:

- a. The petitioner or the person who was the subject of the waiver order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver;
- b. The alternative means for ensuring that the public health, safety, and welfare will be adequately protected after issuance of the waiver order have been demonstrated to be insufficient; or
- c. The subject of the waiver order has failed to comply with all conditions contained in the order.

**1.8(23) *Violations.*** Violation of a condition in a waiver order shall be treated as a violation of the particular rule for which the waiver was granted. As a result, the recipient of a waiver under this rule who violates a condition of the waiver may be subject to the same remedies or penalties as a person who violates the rule at issue.

**1.8(24) *Defense.*** After the commission issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked.

**1.8(25) *Judicial review.*** Judicial review of the commission's decision to grant or deny a waiver petition may be taken in accordance with Iowa Code chapter 17A.  
[ARC 5422C, IAB 2/10/21, effective 3/17/21]

These rules are intended to implement Iowa Code section 17A.9A and Iowa Code chapters 99D and 99F.

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<sup>o</sup> Two or more ARCs

<sup>1</sup> Effective date of Item 1, subrule 1.6(4), delayed by the Administrative Rules Review Committee at its meeting held September 8, 1998, until the adjournment of the 1999 Session of the General Assembly.

<sup>2</sup> Effective date of 1.8 delayed 70 days by the Administrative Rules Review Committee at its meeting held March 10, 2000.

CHAPTER 2  
RULE MAKING AND DECLARATORY ORDERS

[Prior to 11/19/86, Racing Commission[693]]  
[Prior to 11/18/87, Racing and Gaming Division[195]]

**491—2.1(17A) Applicability.** Except to the extent otherwise expressly provided by statute, all rules adopted by the agency are subject to the provisions of Iowa Code chapter 17A, the Iowa administrative procedure Act, and the provisions of this chapter.

**491—2.2(17A) Advice on possible rules before notice of proposed rule adoption.** In addition to seeking information by other methods, the racing and gaming commission (commission) may, before publication of a Notice of Intended Action under Iowa Code section 17A.4(1) “a,” solicit comments from the public on a subject matter of possible rule making by the commission by causing notice to be published in the Iowa Administrative Bulletin of the subject matter and indicating where, when, and how persons may comment.

**491—2.3(17A) Public rule-making docket.**

**2.3(1) Docket maintained.** The commission shall maintain a current public rule-making docket.

**2.3(2) Anticipated rule making.** The rule-making docket shall list each anticipated rule-making proceeding. A rule-making proceeding is deemed “anticipated” from the time a draft of proposed rules is distributed for internal discussion within the commission. For each anticipated rule-making proceeding, the docket shall contain a listing of the precise subject matter which may be submitted for consideration by the commission for subsequent proposal under the provisions of Iowa Code section 17A.4(1) “a,” the name and address of commission personnel with whom persons may communicate with respect to the matter, and an indication of the present status within the commission of that possible rule. The commission may also include in the docket other subjects upon which public comment is desired.

**2.3(3) Pending rule-making proceedings.** The rule-making docket shall list each pending rule-making proceeding. A rule-making proceeding is pending from the time it is commenced, by publication in the Iowa Administrative Bulletin of a Notice of Intended Action pursuant to Iowa Code section 17A.4(1) “a,” to the time it is terminated, by publication of a Notice of Termination in the Iowa Administrative Bulletin or the rule becoming effective. For each rule-making proceeding, the docket shall indicate:

- a. The subject matter of the proposed rule;
- b. A citation to all published notices relating to the proceeding;
- c. Where written submissions on the proposed rule may be inspected;
- d. The time during which written submissions may be made;
- e. The names of persons who have made written requests for an opportunity to make oral presentations on the proposed rule, where those requests may be inspected, and where and when oral presentations may be made;
- f. Whether a written request for the issuance of a regulatory analysis, or a concise statement of reasons, has been filed, and whether such written request, analysis, or statement may be inspected;
- g. The current status of the proposed rule and any commission determinations with respect thereto;
- h. Any known timetable for commission decisions or other action in the proceedings;
- i. The date of the rule’s adoption;
- j. The date of the rule’s filing, indexing, and publication;
- k. The date on which the rule will become effective; and
- l. Where the rule-making record may be inspected.

**491—2.4(17A) Notice of proposed rule making.**

**2.4(1) Contents.** At least 35 days before the adoption of a rule the commission shall cause Notice of Intended Action to be published in the Iowa Administrative Bulletin. The Notice of Intended Action shall include:

- a. A brief explanation of the purpose of the proposed rule;
- b. The specific legal authority for the proposed rule;
- c. Except to the extent impracticable, the text of the proposed rule;
- d. Where, when, and how persons may present their views on the proposed rule; and
- e. Where, when, and how persons may demand an oral proceeding on the proposed rule if the notice does not already provide for one.

Where inclusion of the complete text of a proposed rule in the Notice of Intended Action is impracticable, the commission shall include in the notice a statement fully describing the specific subject matter of the omitted portion of the text of the proposed rule, the specific issues to be addressed by that omitted text of the proposed rule, and the range of possible choices being considered by the commission for the resolution of each of those issues.

**2.4(2) *Incorporation by reference.*** A proposed rule may incorporate other materials by reference only if it complies with all of the requirements applicable to the incorporation by reference of other materials in an adopted rule that are contained in subrule 2.12(2) of this chapter.

**2.4(3) *Copies of notices.*** Persons desiring to receive copies of future Notices of Intended Action by subscription must file with the commission a written request indicating the name and address to which such notices should be sent. The commission will attach the proposed rules to the agenda for the commission meeting in which the rules will be addressed. If the individual desiring a copy of the rules did not receive the rules with the copy of the agenda either through the mail or on the commission web page within seven days after submission of a Notice of Intended Action to the administrative rules coordinator for publication in the Iowa Administrative Bulletin, the commission shall mail or electronically transmit a copy of that notice to subscribers who have filed a written request for either mailing or electronic transmittal with the commission for Notices of Intended Action. The written request shall be accompanied by payment of the subscription price which may cover the full cost of the subscription service, including its administrative overhead and the cost of copying and mailing the Notices of Intended Action for a period of one year.

#### **491—2.5(17A) Public participation.**

**2.5(1) *Written comments.*** For at least 20 days after publication of the Notice of Intended Action, persons may submit argument, data, and views, in writing, on the proposed rule. Such written submissions should identify the proposed rule to which they relate and should be submitted to the Racing and Gaming Commission, 1300 Des Moines Street, Suite 100, Des Moines, Iowa 50309.

**2.5(2) *Oral proceedings.*** The commission may, at any time, schedule an oral proceeding on a proposed rule. The commission shall schedule an oral proceeding on a proposed rule if, within 20 days after the published Notice of Intended Action, a written request for an opportunity to make oral presentations is submitted to the commission by the administrative rules review committee, a governmental subdivision, an agency, an association having not less than 25 members, or at least 25 persons. That request must also contain the following additional information:

1. A request by one or more individual persons must be signed by each of them and include the address and telephone number of each of them.
2. A request by an association must be signed by an officer or designee of the association and must contain a statement that the association has at least 25 members and the address and telephone number of the person signing that request.
3. A request by an agency or governmental subdivision must be signed by an official having authority to act on behalf of the entity and must contain the address and telephone number of the person signing that request.

**2.5(3) *Conduct of oral proceedings.***

a. *Applicability.* This subrule applies only to those oral rule-making proceedings in which an opportunity to make oral presentations is authorized or required by Iowa Code section 17A.4(1)“b.”

b. *Scheduling and notice.* An oral proceeding on a proposed rule may be held in one or more locations and shall not be held earlier than 20 days after notice of its location and time is published in

the Iowa Administrative Bulletin. That notice shall also identify the proposed rule by ARC number and citation to the Iowa Administrative Bulletin.

*c. Presiding officer.* The commission, a member of the commission, or another person designated by the commission who will be familiar with the substance of the proposed rule, shall preside at the oral proceeding on a proposed rule. If the commission does not preside, the presiding officer shall prepare a memorandum for consideration by the commission summarizing the contents of the presentations made at the oral proceeding unless the commission determines that such a memorandum is unnecessary because the commission will personally listen to or read the entire transcript of the oral proceeding.

*d. Conduct of proceeding.* At an oral proceeding on a proposed rule, persons may make oral statements and make documentary and physical submissions, which may include data, views, comments or arguments concerning the proposed rule. Persons wishing to make oral presentations at such a proceeding are encouraged to notify the commission at least one business day prior to the proceeding and indicate the general subject of their presentations. At the proceeding, those who participate shall indicate their names and addresses, identify any persons or organizations they may represent, and provide any other information relating to their participation deemed appropriate by the presiding officer. Oral proceedings shall be open to the public and shall be recorded by stenographic or electronic means.

(1) At the beginning of the oral proceeding, the presiding officer shall give a brief synopsis of the proposed rule, a statement of the statutory authority for the proposed rule, and the reasons for the commission decision to propose the rule. The presiding officer may place time limitations on individual oral presentations when necessary to ensure the orderly and expeditious conduct of the oral proceeding. To encourage joint oral presentations and to avoid repetition, additional time may be provided for persons whose presentations represent the views of other individuals as well as their own views.

(2) Persons making oral presentations are encouraged to avoid restating matters which have already been submitted in writing.

(3) To facilitate the exchange of information, the presiding officer may, where time permits, open the floor to questions or general discussion.

(4) The presiding officer shall have the authority to take any reasonable action necessary for the orderly conduct of the meeting.

(5) Physical and documentary submissions presented by participants in the oral proceeding shall be submitted to the presiding officer. Such submissions become the property of the commission.

(6) The oral proceeding may be continued by the presiding officer to a later time without notice other than by announcement at the hearing.

(7) Participants in an oral proceeding shall not be required to take an oath or to submit to cross-examination. However, the presiding officer in an oral proceeding may question participants and permit the questioning of participants by other participants about any matter relating to that rule-making proceeding, including any prior written submissions made by those participants in that proceeding; but no participant shall be required to answer any questions.

(8) The presiding officer in an oral proceeding may permit rebuttal statements and request the filing of written statements subsequent to the adjournment of the oral presentations.

**2.5(4) Additional information.** In addition to receiving written comments and oral presentations on a proposed rule according to the provisions of this rule, the commission may obtain information concerning a proposed rule through any other lawful means deemed appropriate under the circumstances.

**2.5(5) Accessibility.** The commission shall schedule oral proceedings in rooms accessible to and functional for persons with physical disabilities. Persons who have special requirements should contact the commission at (515)281-7352 in advance to arrange access or other needed services.

[ARC 0734C, IAB 5/15/13, effective 6/19/13]

#### **491—2.6(17A) Regulatory analysis.**

**2.6(1) Qualified requesters for regulatory analysis—business impact.** The commission shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4A(1) after a proper request from:

*a.* The administrative rules review committee,

b. The administrative rules coordinator.

**2.6(2) *Time period for analysis.*** Upon receipt of a timely request for a regulatory analysis, the commission shall adhere to the time lines described in Iowa Code section 17A.4A(4).

**2.6(3) *Contents of request.*** A request for a regulatory analysis is made when it is mailed or delivered to the commission. The request shall be in writing and satisfy the requirements of Iowa Code section 17A.4A(1).

**2.6(4) *Contents of concise summary.*** The contents of the concise summary shall conform to the requirements of Iowa Code sections 17A.4A(2), (3) and (5).

**2.6(5) *Publication of a concise summary.*** The commission shall make available, to the maximum extent feasible, copies of the published summary in conformance with Iowa Code section 17A.4A(5).

**2.6(6) *Regulatory analysis contents—rules review committee or rules coordinator.*** When a regulatory analysis is issued in response to a written request from the administrative rules review committee, or the administrative rules coordinator, the regulatory analysis shall conform to the requirements of Iowa Code sections 17A.4A(1), (2)“a” and “b,” and (3) unless a written request expressly waives one or more of the items listed in the section.

#### **491—2.7(17A,25B) Fiscal impact statement.**

**2.7(1)** A proposed rule that mandates additional combined expenditures exceeding \$100,000 by all affected political subdivisions or agencies and entities which contract with political subdivisions to provide services must be accompanied by a fiscal impact statement outlining the costs associated with the rule. A fiscal impact statement must satisfy the requirements of Iowa Code section 25B.6.

**2.7(2)** If the commission determines at the time it adopts a rule that the fiscal impact statement upon which the rule is based contains errors, the commission shall, at the same time, issue a corrected fiscal impact statement and publish the correct fiscal impact statement in the Iowa Administrative Bulletin.

#### **491—2.8(17A) Time and manner of rule adoption.**

**2.8(1) *Time of adoption.*** The commission shall not adopt a rule until the period for making written submissions and oral presentations has expired. Within 180 days after the later of the publication of the Notice of Intended Action, or the end of oral proceedings thereon, the commission shall adopt a rule pursuant to the rule-making proceeding or terminate the proceeding by publication of a notice to that effect in the Iowa Administrative Bulletin.

**2.8(2) *Consideration of public comment.*** Before the adoption of a rule, the commission shall consider fully all of the written submissions and oral submissions received in that rule-making proceeding or any memorandum summarizing such oral submissions, and any regulatory analysis or fiscal impact statement issued in that rule-making proceeding.

**2.8(3) *Reliance on commission expertise.*** Except as otherwise provided by law, the commission may use its own experience, technical competence, specialized knowledge, and judgment in the adoption of a rule.

#### **491—2.9(17A) Variance between adopted rule and published notice of proposed rule adoption.**

**2.9(1)** The commission shall not adopt a rule that differs from the rule proposed in the Notice of Intended Action on which the rule is based unless:

a. The differences are within the scope of the subject matter announced in the Notice of Intended Action and are in character with the issues raised in that notice; and

b. The differences are a logical outgrowth of the contents of that Notice of Intended Action and the comments submitted in response thereto; and

c. The Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question.

**2.9(2)** In determining whether the Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question, the commission shall consider the following factors:

- a.* The extent to which the person who will be affected by the rule should have understood that the rule-making proceeding on which it is based could affect their interests;
- b.* The extent to which the subject matter of the rule or the issues determined by the rule are different from the subject matter or issues contained in the Notice of Intended Action; and
- c.* The extent to which the effects of the rule differ from the effects of the proposed rule contained in the Notice of Intended Action.

**2.9(3)** The commission shall commence a rule-making proceeding within 60 days of its receipt of a petition for rule making seeking the amendment or repeal of a rule that differs from the proposed rule contained in the Notice of Intended Action upon which the rule is based, unless the commission finds that the differences between the adopted rule and the proposed rule are so insubstantial as to make such a rule-making proceeding wholly unnecessary. A copy of any such finding and the petition to which it responds shall be sent to petitioner, the administrative rules coordinator, and the administrative rules review committee, within three days of its issuance.

**2.9(4)** Concurrent rule-making proceedings. Nothing in this rule disturbs the discretion of the commission to initiate, concurrently, several different rule-making proceedings on the same subject with several different published Notices of Intended Action.

#### **491—2.10(17A) Exemption from public rule-making procedures.**

**2.10(1)** *Omission of notice and comment.* To the extent the commission for good cause finds that public notice and participation are unnecessary, impracticable, or contrary to the public interest in the process of adopting a particular rule, the commission may adopt that rule without publishing advance Notice of Intended Action in the Iowa Administrative Bulletin and without providing for written or oral public submissions prior to its adoption. The commission shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

**2.10(2)** *Public proceedings on rules adopted without them.* The commission may, at any time, commence a standard rule-making proceeding for the adoption of a rule that is identical or similar to a rule it adopts in reliance upon subrule 2.10(1). Upon written petition by a governmental subdivision, the administrative rules review committee, an agency, the administrative rules coordinator, an association having not less than 25 members, or at least 25 persons, the commission shall commence a standard rule-making proceeding for any rule specified in the petition that was adopted in reliance upon subrule 2.10(1). Such a petition must be filed within one year of the publication of the specified rule in the Iowa Administrative Bulletin as an adopted rule. The rule-making proceeding on that rule must be commenced within 60 days of the receipt of such a petition. After a standard rule-making proceeding commenced pursuant to this subrule, the commission may either readopt the rule it adopted without benefit of all usual procedures on the basis of subrule 2.10(1), or may take any other lawful action, including the amendment or repeal of the rule in question, with whatever further proceedings are appropriate.

#### **491—2.11(17A) Concise statement of reasons.**

**2.11(1)** *General.* When requested by a person, either prior to the adoption of a rule or within 30 days after its publication in the Iowa Administrative Bulletin as an adopted rule, the commission shall issue a concise statement of reasons for the rule. Requests for such a statement must be in writing and be delivered to the Racing and Gaming Commission, 1300 Des Moines Street, Suite 100, Des Moines, Iowa 50309. The request should indicate whether the statement is sought for all or only a specified part of the rule. Requests will be considered made on the date received.

**2.11(2)** *Contents.* The concise statement of reasons shall contain:

- a.* The reasons for adopting the rule;
- b.* An indication of any change between the text of the proposed rule contained in the published Notice of Intended Action and the text of the rule as finally adopted, with the reasons for any such change;
- c.* The principal reasons urged in the rule-making proceeding for and against the rule, and the commission's reasons for overruling the arguments made against the rule.

**2.11(3) *Time of issuance.*** After a proper request, the commission shall issue a concise statement of reasons by the later of the time the rule is adopted or 35 days after receipt of the request.  
[ARC 0734C, IAB 5/15/13, effective 6/19/13]

**491—2.12(17A) Contents, style, and form of rule.**

**2.12(1) *Contents.*** Each rule adopted by the commission shall contain the text of the rule and, in addition:

- a. The date the commission adopted the rule;
- b. A brief explanation of the principal reasons for the rule-making action if such reasons are required by Iowa Code section 17A.4(1) “b” or the commission in its discretion decides to include such reasons;
- c. A reference to all rules repealed, amended, or suspended by the rule;
- d. A reference to the specific statutory or other authority authorizing adoption of the rule;
- e. Any findings required by any provision of law as a prerequisite to adoption or effectiveness of the rule;
- f. A brief explanation of the principal reasons for the failure to provide for waivers to the rule if no waiver provision is included and a brief explanation of any waiver or special exceptions provided in the rule if such reasons are required by Iowa Code section 17A.4(1) “b” or the commission in its discretion decides to include such reasons; and
- g. The effective date of the rule.

**2.12(2) *Incorporation by reference.*** The commission may incorporate by reference in a proposed or adopted rule, and without causing publication of the incorporated matter in full, all or any part of a code, standard, rule, or other matter if the commission finds that the incorporation of its text in the commission proposed or adopted rule would be unduly cumbersome, expensive, or otherwise inexpedient. The reference in the commission proposed or adopted rule shall fully indicate the precise subject and the general contents of the incorporated matter and shall state that the proposed or adopted rule does not include any later amendments or editions of the incorporated matter. The commission may incorporate such matter by reference in a proposed or adopted rule only if the commission makes copies of it readily available to the public. The rule shall state how and where copies of the incorporated matter may be obtained at cost from the commission, and how and where copies may be obtained from the agency of the United States, this state, another state, or the organization, association, or persons, originally issuing that matter. The commission shall retain permanently a copy of any materials incorporated by reference in a rule of the commission.

If the commission adopts standards by reference to another publication, it shall provide a copy of the publication containing the standards to the administrative rules coordinator for deposit in the state law library and may make the standards available electronically.

**2.12(3) *References to materials not published in full.*** When the administrative code editor decides to omit the full text of a proposed or adopted rule because publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient, the commission shall prepare and submit to the administrative code editor for inclusion in the Iowa Administrative Bulletin and Iowa Administrative Code a summary statement describing the specific subject matter of the omitted material. This summary statement shall include the title and a brief description sufficient to inform the public of the specific nature and subject matter of the proposed or adopted rules, and of significant issues involved in these rules. The summary statement shall also describe how a copy of the full text of the proposed or adopted rule, including any unpublished matter and any matter incorporated by reference, may be obtained from the commission. The commission will provide a copy of that full text at the actual cost upon request and shall make copies of the full text available for review at the state law library and may make the standards available electronically.

At the request of the administrative code editor, the commission shall provide a proposed statement explaining why publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient.

**2.12(4) *Style and form.*** In preparing its rules, the commission shall follow the uniform numbering system, form, and style prescribed by the administrative rules coordinator.

**491—2.13(17A) Agency rule-making record.**

**2.13(1) *Requirement.*** The commission shall maintain an official rule-making record for each rule it proposes by publication in the Iowa Administrative Bulletin of a Notice of Intended Action, or adopts. The rule-making record and materials incorporated by reference must be available for public inspection.

**2.13(2) *Contents.*** The commission rule-making record shall contain:

*a.* Copies of all publications in the Iowa Administrative Bulletin with respect to the rule or the proceeding upon which the rule is based and any file-stamped copies of commission submissions to the administrative rules coordinator concerning that rule or the proceeding upon which it is based;

*b.* Copies of any portions of the commission's public rule-making docket containing entries relating to the rule or the proceeding upon which the rule is based;

*c.* All written petitions, requests, and submissions received by the commission, and all other written materials of a factual nature as distinguished from opinion that are relevant to the merits of the rule and that were created or compiled by the commission and considered by the administrator, in connection with the formulation, proposal, or adoption of the rule or the proceeding upon which the rule is based, except to the extent that the commission is authorized by law to keep them confidential; provided, however, that when any such materials are deleted because they are authorized by law to be kept confidential, the commission shall identify in the record the particular materials deleted and state the reasons for that deletion;

*d.* Any official transcript of oral presentations made in the proceeding upon which the rule is based or, if not transcribed, the stenographic record or electronic recording of those presentations, and any memorandum prepared by a presiding officer summarizing the contents of those presentations;

*e.* A copy of any regulatory analysis or fiscal impact statement prepared for the proceeding upon which the rule is based;

*f.* A copy of the rule and any concise statement of reasons prepared for that rule;

*g.* All petitions for amendment or repeal or suspension of the rule;

*h.* A copy of any objection to the issuance of that rule without public notice and participation that was filed pursuant to Iowa Code section 17A.4(2) by the administrative rules review committee, the governor, or the attorney general;

*i.* A copy of any objection to the rule filed by the administrative rules review committee, the governor, or the attorney general pursuant to Iowa Code section 17A.4(4), and any commission response to that objection;

*j.* A copy of any significant written criticism of the rule, including a summary of any petitions for waiver of the rule; and

*k.* A copy of any executive order concerning the rule.

**2.13(3) *Effect of record.*** Except as otherwise required by a provision of law, the commission rule-making record required by this rule need not constitute the exclusive basis for commission action on that rule.

**2.13(4) *Maintenance of record.*** The commission shall maintain the rule-making record for a period of not less than five years from the later of the date the rule to which it pertains became effective, the date of the Notice of Intended Action, or the date of any written criticism as described in 2.13(2) "g," "h," "i," or "j."

**491—2.14(17A) Filing of rules.** The commission shall file each rule it adopts in the office of the administrative rules coordinator. The filing must be executed as soon after adoption of the rule as is practicable. At the time of filing, each rule must have attached to it any fiscal impact statement and any concise statement of reasons that was issued with respect to that rule, if applicable. If a fiscal impact statement or statement of reasons for that rule was not issued until a time subsequent to the filing of that rule, the note or statement must be attached to the filed rule within five working days after the note

or statement is issued. In filing a rule, the commission shall use the standard form prescribed by the administrative rules coordinator.

**491—2.15(17A) Effectiveness of rules prior to publication.**

**2.15(1) *Grounds.*** The commission may make a rule effective after its filing at any stated time prior to 35 days after its indexing and publication in the Iowa Administrative Bulletin if it finds that a statute so provides, the rule confers a benefit or removes a restriction on some segment of the public, or that the effective date of the rule is necessary to avoid imminent peril to the public health, safety, or welfare. The commission shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

**2.15(2) *Special notice.*** When the commission makes a rule effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2)“b”(3), the commission shall employ all reasonable efforts to make its contents known to the persons who may be affected by that rule prior to the rule’s indexing and publication. The term “all reasonable efforts” requires the commission to employ the most effective and prompt means of notice rationally calculated to inform potentially affected parties of the effectiveness of the rule that is justified and practical under the circumstances considering the various alternatives available for this purpose, the comparative costs to the commission of utilizing each of those alternatives, and the harm suffered by affected persons from any lack of notice concerning the contents of the rule prior to its indexing and publication. The means that may be used for providing notice of such rules prior to their indexing and publication include, but are not limited to, any one or more of the following means: radio, newspaper, television, signs, mail, telephone, personal notice or electronic means.

A rule made effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2)“b”(3) shall include in that rule a statement describing the reasonable efforts that will be used to comply with the requirements of subrule 2.15(2).

**491—2.16(17A) General statements of policy.**

**2.16(1) *Compilation, indexing, public inspection.*** The commission shall maintain an official, current, and dated compilation that is indexed by subject, containing all of its general statements of policy within the scope of Iowa Code section 17A.2(10)“a,” “c,” “f,” “g,” “h,” “k.” Each addition to, change in, or deletion from the official compilation must also be dated, indexed, and a record thereof kept. Except for those portions containing rules governed by Iowa Code section 17A.2(7)“f,” or otherwise authorized by law to be kept confidential, the compilation must be made available for public inspection and copying.

**2.16(2) *Enforcement of requirements.*** A general statement of policy subject to the requirements of this subsection shall not be relied on by the commission to the detriment of any person who does not have actual, timely knowledge of the contents of the statement until the requirements of subrule 2.16(1) are satisfied. This provision is inapplicable to the extent necessary to avoid imminent peril to the public health, safety, or welfare.

**491—2.17(17A) Review by commission of rules.**

**2.17(1)** Any interested person, association, agency, or political subdivision may submit a written request to the administrative rules coordinator requesting the commission to conduct a formal review of a specified rule. Upon approval of that request by the administrative rules coordinator, the commission shall conduct a formal review of a specified rule to determine whether a new rule should be adopted instead or the rule should be amended or repealed. The commission may refuse to conduct a review if it has conducted such a review of the specified rule within five years prior to the filing of the written request.

**2.17(2)** In conducting the formal review, the commission shall prepare within a reasonable time a written report summarizing its findings, its supporting reasons, and any proposed course of action. The report must include a concise statement of the commission’s findings regarding the rule’s effectiveness in achieving its objectives, including a summary of any available supporting data. The report shall

also concisely describe significant written criticisms of the rule received during the previous five years, including a summary of any petitions for waiver of the rule received by the commission or granted by the commission. The report shall describe alternative solutions to resolve the criticisms of the rule, the reasons any were rejected, and any changes made in the rule in response to the criticisms as well as the reasons for the changes. A copy of the commission’s report shall be sent to the administrative rules review committee and the administrative rules coordinator. The report must also be available for public inspection.

**491—2.18(17A) Petition for rule making.** Any interested person or agency may file a petition for rule making with the commission. The petition for rule making shall be filed in the Racing and Gaming Commission Office, 1300 Des Moines Street, Suite 100, Des Moines, Iowa 50309. The petition shall either be mailed certified, return receipt requested, or may be delivered in person. An additional copy may be provided if the petitioner wishes to retain a file-stamped copy of the petition. The petition may be either typewritten or legibly printed in ink and must substantially conform to the following form:

RACING AND GAMING COMMISSION  
1300 Des Moines Street, Suite 100  
Des Moines, Iowa 50309

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Petition by (Name of Petitioner)  
for the (adoption, amendment,  
or repeal) of rules relating to  
(state subject matter).



PETITION FOR  
RULE MAKING

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The petition must provide the following information:

1. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.
2. A citation to any law deemed relevant to the commission’s authority to take the action urged or to the desirability of that action.
3. A brief summary of petitioner’s arguments in support of the action urged in the petition.
4. A brief summary of any data supporting the action urged in the petition.
5. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.

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Petitioner’s signature

**2.18(1) *Petition signed.*** The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner’s representative and a statement indicating the person to whom communications concerning the petition should be directed.

**2.18(2) *Deny petition.*** The commission may deny a petition because it does not substantially conform to the required form.

**2.18(3) *Procedure after petition is filed.*** Upon filing of the petition, the administrator shall inspect the petition to ensure substantial compliance with the recommended form. If the petition does not contain the text or substance of the proposed amendment or fails to include copies of any cited statute, rule, or evidence, the administrator may reject the petition and return it to the petitioner along with the reasons for the rejection. Petitioner may then correct the reasons for rejection and refile the petition. A petition in substantial compliance with the recommended form shall be filed and stamped, and copies promptly sent to the commission members for further study.

**2.18(4) *Commission action.*** Within 60 days of the filing of a petition, the commission shall meet to consider the petition and shall either grant the petition and commence rule making, or deny the petition and notify the petitioner in writing of the grounds for the denial.

**2.18(5) Copies to administrative rules review committee.** Petitions for rule making and the disposition of such petitions shall be provided to the administrative rules review committee.  
[ARC 0734C, IAB 5/15/13, effective 6/19/13; ARC 5422C, IAB 2/10/21, effective 3/17/21]

**491—2.19(17A) General.** Any interested person may solicit oral or written advice from the administrator concerning the application or interpretation of any statute or administrative rule dealing with the commission. However, unless the request is made pursuant to Iowa Code section 17A.9, petition for declaratory order, any such advice is not binding upon the commission. Petitioners for a declaratory order must have a real and direct interest in a specific fact situation that may affect their legal rights, duties or responsibilities under statutes or regulations administered by the commission.

**491—2.20(17A) Petition for declaratory order.** Any person may file a petition with the commission for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the commission, at 1300 Des Moines Street, Suite 100, Des Moines, Iowa 50309. A petition is deemed filed when it is received by that office. The commission shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the commission an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

RACING AND GAMING COMMISSION  
1300 Des Moines Street, Suite 100  
Des Moines, Iowa 50309

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Petition by (Name of Petitioner)  
for a Declaratory Order on  
(Cite provisions of law involved).



PETITION FOR  
DECLARATORY ORDER

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The petition must provide the following information:

1. A clear and concise statement of all relevant facts on which the order is requested.
2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting provided for by 491—2.26(17A).

The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative and a statement indicating the person to whom communications concerning the petition should be directed.

[ARC 0734C, IAB 5/15/13, effective 6/19/13]

**491—2.21(17A) Notice of petition.** Within 15 days after receipt of a petition for a declaratory order, the commission shall give notice of the petition to all persons not served by the petitioner pursuant to rule 2.25(17A) to whom notice is required by any provision of law or who have requested notice of petitions for declaratory orders. The commission may also give notice to any other persons.

**491—2.22(17A,99D,99F) Intervention.**

**2.22(1)** Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 30 days of the filing of a petition for declaratory order shall be allowed to intervene in a proceeding for a declaratory order.

**2.22(2)** Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the commission.

**2.22(3)** A petition for intervention shall be filed at the Racing and Gaming Commission Office, 1300 Des Moines Street, Suite 100, Des Moines, Iowa 50309. Such a petition is deemed filed when it is received by that office. The commission will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

RACING AND GAMING COMMISSION  
1300 Des Moines Street, Suite 100  
Des Moines, Iowa 50309

Petition by (Name of Original Petitioner)  
for a Declaratory Order on (Cite  
provisions of law cited in original petition).



PETITION FOR  
INTERVENTION

The petition for intervention must provide the following information:

1. Facts supporting the intervenor’s standing and qualifications for intervention.
2. A citation and the relevant language of any additional statutes, rules, or orders and any other, additional, relevant law.
3. The answers to the original summary of the reasons urged by the intervenor in support of those answers.
4. Reasons for requesting intervention and disclosure of the intervenor’s interest in the outcome.
5. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
6. The names and addresses of any additional persons, or a description of any class of persons, known by intervenor to be affected by, or interested in, the questions presented.
7. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

The petition must be dated and signed by the intervenor or the intervenor’s representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor’s representative, and a statement indicating the person to whom communications concerning the petition should be directed.

[ARC 0734C, IAB 5/15/13, effective 6/19/13]

**491—2.23(17A) Briefs.** The petitioner or any intervenor may file a brief in support of the position urged. The commission may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

**491—2.24(17A) Inquiries.** Inquiries concerning the status of a declaratory order proceeding may be made to the Administrator, Racing and Gaming Commission, 1300 Des Moines Street, Suite 100, Des Moines, Iowa 50309.

[ARC 0734C, IAB 5/15/13, effective 6/19/13]

**491—2.25(17A) Service and filing of petitions and other papers.**

**2.25(1)** *When service required.* Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons

identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

**2.25(2) Filing—when required.** All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the Racing and Gaming Commission Office, 1300 Des Moines Street, Suite 100, Des Moines, Iowa 50309. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the commission.

[ARC 0734C, IAB 5/15/13, effective 6/19/13]

**491—2.26(17A) Consideration.** Upon request by petitioner, the commission must schedule a brief and informal meeting between the original petitioner, all intervenors, and the commission, a member of the commission, or a member of the staff of the commission, to discuss the questions raised. The commission may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the commission by any person.

**491—2.27(17A) Action on petition.**

**2.27(1)** Within the time allowed by Iowa Code section 17A.9(5), after receipt of a petition for a declaratory order, the administrator or designee shall take action on the petition as required by Iowa Code section 17A.9(5).

**2.27(2)** The date of issuance of an order or of a refusal to issue an order is defined as the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

**491—2.28(17A) Refusal to issue order.**

**2.28(1)** The commission shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1) and may refuse to issue a declaratory order on some or all questions raised for the following reasons.

1. The petition does not substantially comply with the required form.
2. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the commission to issue an order.
3. The commission does not have jurisdiction over the questions presented in the petition.
4. The questions presented by the petition are also presented in a current rule making, contested case, or other commission or judicial proceeding, that may definitively resolve them.
5. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
6. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
7. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.
8. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge a commission decision already made.
9. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.
10. The petitioner requests the commission to determine whether a statute is unconstitutional on its face.

**2.28(2)** A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final commission action on the petition.

**2.28(3)** Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

**491—2.29(17A) Contents of declaratory order—effective date.** In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion. A declaratory order is effective on the date of issuance.

**491—2.30(17A) Copies of orders.** A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

**491—2.31(17A) Effect of a declaratory order.** A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the commission, the petitioner, and any intervenors (who consent to be bound) and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the commission. The issuance of a declaratory order constitutes final commission action on the petition.

These rules are intended to implement Iowa Code chapters 17A, 99D and 99F.

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CHAPTER 5  
TRACK, GAMBLING STRUCTURE, AND EXCURSION GAMBLING BOAT  
LICENSEES' RESPONSIBILITIES

[Prior to 11/19/86, Racing Commission[693]]

[Prior to 11/18/87, Racing and Gaming Division[195]]

[Prior to 8/9/00, see also 491—Chs 20 and 25]

**491—5.1(99D,99F) In general.** For purposes of this chapter, the requirements placed upon an applicant shall become a requirement to the licensee once a license to race or operate a gaming facility has been granted. Every license is granted upon the condition that the license holder shall accept, observe, and enforce the rules and regulations of the commission. It is the affirmative responsibility and continuing duty of each officer, director, and employee of said license holder to comply with the requirements of the application and conditions of the license and to observe and enforce the rules. The holding of a license is a privilege. The burden of proving qualifications for the privilege to receive any license is on the licensee at all times. A licensee must accept all risks of adverse public notice or public opinion, embarrassment, criticism, or financial loss that may result from action with respect to a license. Licensees further covenant and agree to hold harmless and indemnify the Iowa racing and gaming commission from any claim arising from any action of the commission in connection with that license. This chapter applies to a license to race or operate a gaming facility unless otherwise noted.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—5.2(99D,99F) Annual reports.** Licensees shall submit audits to the commission as required by Iowa Code sections 99D.20 and 99F.13.

**5.2(1)** The audit of financial transactions and condition of licensee's operation shall include:

- a. An internal control letter;
- b. Documentation that the audit shall be conducted by certified public accountants authorized to practice in the state of Iowa under Iowa Code chapter 542;
- c. A balance sheet; and
- d. A profit-and-loss statement pertaining to the licensee's activities in the state, including a breakdown of expenditures and subsidies.

**5.2(2)** If the licensee's fiscal year does not correspond to the calendar year, a supplemental schedule indicating financial activities on a calendar-year basis shall be included in the report.

**5.2(3)** In the event of a license termination, change in business entity, or material change in ownership, the administrator may require the filing of an interim report, as of the date of occurrence of the event. The filing due date shall be the later of 30 calendar days after notification to the licensee or 30 calendar days after the date of the occurrence of the event, unless an extension is granted.

**5.2(4)** An engagement letter for the audit between the licensee and auditing firm shall be available upon request. The engagement letter requirement does not apply to the licensed qualified sponsoring organization. Conditions of engagement for the audit shall include, at a minimum, the following requirements:

a. The auditing firm shall report any material errors, irregularities or illegal acts that come to the firm's attention during the course of an audit to the licensee's audit committee or senior management as required by the rules of professional conduct that apply to the auditing firm. The licensee shall report such material errors, irregularities or illegal acts to the commission in a timely manner following reporting to the licensee's audit committee or senior management.

b. The auditing firm shall inform the commission in writing of matters that come to the firm's attention that represent significant deficiencies in the design or operation of the internal control structure.

c. The audit supervisor or an audit staff member conducting the audit must have experience or training in the gaming industry.

d. The auditing firm agrees to respond timely to all reasonable requests of successor auditors.

e. The auditing firm agrees, if requested by the commission, to provide licensee management and the commission with recommendations designed to help the licensee make improvements in its internal control structure and operation, and other matters that are discovered during the audit.

**5.2(5)** For a licensed subsidiary of a parent company, an audit of the parent company may be filed with the following conditions:

*a.* The consolidated financial statements shall include in the supplemental schedule, or elsewhere as determined by the licensee and auditing firm, for each licensee: balance sheets, statements of operations, statements of cash flows, schedules of operating expenses and schedules of adjusted gross revenue and taxes and fees paid to governmental agencies.

*b.* Any internal audit staff assisting with the audit shall report any material errors, irregularities or illegal acts that come to the staff's attention during the course of an audit to the licensee's audit committee or senior management as required by the rules of professional conduct. The licensee shall report such material errors, irregularities or illegal acts to the commission in a timely manner following reporting to the licensee's audit committee or senior management.

*c.* All other requirements in this rule are met and included for each entity licensed in Iowa unless an exception is granted in writing by the commission (or administrator).

**5.2(6)** The annual audit report required by Iowa Code section 99D.20 shall include a schedule detailing the following information: number of performances; attendance; regulatory fee; total mutuel handle and taxes paid to the state, city, and county; unclaimed winnings; purses paid indicating sources; total breakage and disbursements; and the disbursements of 1 percent of exotic wagers on three or more racing animals.

**5.2(7)** The annual audit report required by Iowa Code section 99F.13 shall include:

*a.* A schedule detailing a weekly breakdown of adjusted gross revenue; taxes paid to the state, city, county, and county endowment fund; and regulatory fees.

*b.* A report on whether material weaknesses in internal accounting control exist.

**5.2(8)** Internal control records, compliance records, marketing expenses, and supplemental schedules included in the annual reports shall be kept confidential, as outlined in Iowa Code section 99F.12(4).

[ARC 1876C, IAB 2/18/15, effective 3/25/15; ARC 4378C, IAB 3/27/19, effective 5/1/19; ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—5.3(99D,99F) Information.** The licensee shall submit all information specifically requested by the commission or commission representative.

**491—5.4(99D,99F) Uniform requirements.**

**5.4(1)** *Maintenance of premises and facilities.* Each licensee shall at all times maintain its premises and facilities so as to be neat and clean, well landscaped, painted and in good repair, handicapped accessible, with special consideration for the comfort and safety of patrons, employees, and other persons whose business requires their attendance.

**5.4(2)** *Facilities for commission.* Each licensee shall provide reasonable, adequately furnished office space, including utilities, direct long-distance access for voice and data lines, custodial services, and necessary office equipment, and, if applicable, work space on the boat for the exclusive use of the commission employees and officials. The licensee shall also make available appropriate parking places for commission staff.

**5.4(3)** *Sanitary facilities for patrons.* Each licensee shall, on every day of operation, provide adequate and sanitary toilets and washrooms and furnish free drinking water for patrons and persons having business on the licensee's premises.

**5.4(4)** *First-aid room.*

*a.* During all hours of operation, each licensee shall equip and maintain adequate first-aid facilities and have, at a minimum, one employee trained in CPR, first aid, and the use of the automated external defibrillator (AED). During live racing at horse racetracks and while excursion gambling boats are cruising, the licensee shall have present either a physician, a physician assistant, a registered nurse, a licensed practical nurse, a paramedic, or an emergency medical technician.

*b.* All individuals specified under paragraph 5.4(4) "a" must be currently licensed or certified, including active status, in accordance with the requirements of the Iowa department of public health.

c. Each licensee is required to have a properly functioning and readily accessible AED at the licensee's facility.

**5.4(5) Security force.**

a. *Peace officer.* Each licensee shall ensure that a person who is a certified peace officer is present as outlined in the facility's security plan approved by the commission. A certified peace officer pursuant to this rule must be employed by a law enforcement agency and have police powers.

b. *Employ adequate security.* Each licensee shall employ sufficient security to remove from the licensed premises a person violating a provision of Iowa Code chapter 99D or 99F, commission rules, or orders; any person deemed to be undesirable by racing and gaming commission officials; or any person engaging in a fraudulent practice. Security shall also be provided in and about the premises to secure restricted areas including, but not limited to, the barn area, kennel area, paddock, and racing animal drug testing area.

c. *Incident reports.* The licensee shall be required to file a written report, within 72 hours, detailing any incident in which an employee or patron is detected violating a provision of Iowa Code chapter 99D or 99F, a commission rule or order, or internal controls; or is removed for reasons specified under paragraph 5.4(5) "b." In addition to the written report, the licensee shall provide immediate notification to the commission and DCI representatives on duty or, if representatives are not on duty, provide notification in a manner previously agreed upon by the representatives if the incident involved employee theft, criminal activity, Iowa Code chapter 99D or 99F violations, or gaming receipts.

d. *Ejection or exclusion.* A licensee may eject or exclude any person, licensed or unlicensed, from the premises or a part thereof of the licensee's facility, solely of the licensee's own volition and without any reason or excuse given, provided ejection or exclusion is not founded on constitutionally protected grounds such as race, creed, color, disability, or national origin.

Reports of all ejections or exclusions for any reason, other than voluntary exclusions, shall be made promptly to the commission representative and DCI and shall state the circumstances. The name of the person must be reported when the person is ejected or excluded for more than one gaming day.

The commission may exclude any person ejected by a licensee from any or all pari-mutuel facilities, gambling structures, or excursion gambling boats controlled by any licensee upon a finding that attendance of the person would be adverse to the public interest.

**5.4(6) Firearms possession within licensed facility.**

a. No patron or employee of the licensee, including the security department members, shall possess or be permitted to possess any pistol or firearm within a licensed facility without the express written approval of the administrator unless:

(1) The person is a peace officer, on duty, acting in the peace officer's official capacity; or

(2) The person is a peace officer possessing a valid peace officer permit to carry weapons who is employed by the licensee and who is authorized by the administrator to possess such pistol or firearm while acting on behalf of the licensee within that licensed facility.

b. Each licensee shall post in a conspicuous location at each entrance a sign that may be easily read stating, "Possession of any firearm within the licensed facility without the express written permission of the Iowa racing and gaming commission is prohibited".

**5.4(7) Video recording.** Licensees shall conduct continuous surveillance with the capability of video recording all on-site gambling activities under Iowa administrative rules 661—Chapter 141, promulgated by the department of public safety.

a. "Gambling activities" means participating in any form of wagering as defined by Iowa Code chapter 99F and approved by the commission; the movement, storage, and handling of uncounted gambling revenues; manual exchange of moneys for forms of wagering credit on the gaming floor; entrance of the public onto the gaming floor; and any other activity as determined by the commission administrator or administrator's designee.

b. Commission and DCI representatives shall have unrestricted access to and use of, including independent access capabilities, both live and recorded views and images of the surveillance system.

c. A commission representative may allow a gambling game to be placed in operation pending approval under 661—Chapter 141.

d. A facility may include capabilities within the surveillance system for video recording of other areas of a facility and grounds, provided that commission and DCI access is unrestricted.

**5.4(8) Commission approval of contracts and business arrangements.**

a. *Qualifying agreements.*

(1) All contracts and business arrangements entered into by a facility are subject to commission jurisdiction. Written and verbal contracts and business arrangements involving a related party or in which the term exceeds three years or the total value in a calendar year exceeds \$100,000 regardless of payment method are agreements that qualify for submission to and approval by the commission. Contracts and business arrangements with entities licensed pursuant to rule 491—11.13(99F) to obtain gambling games and implements of gambling, as defined by rule 491—11.1(99F), are exempt from submission to and approval by the commission. For the purpose of this subrule, a qualifying agreement shall be limited to:

1. Any obligation that expends, encumbers, or loans facility assets to anyone other than a not-for-profit entity, a unit of government for the payment of taxes, or an entity that provides water, sewer, gas or electric utility services to the facility.

2. Any disposal of facility assets or provision of goods and services at less than market value to anyone other than a not-for-profit entity or a unit of government.

3. A previously approved qualifying agreement, if consideration exceeds the approved amount in a calendar year by the greater of \$100,000 or 25 percent or if the commission approval date of an ongoing contract is more than five years old.

4. Any type of contract, regardless of value or term, where a third party provides electronic or mechanical access to cash or credit for a patron of the facility. The contract must contain a clause that provides for immediate notification and implementation when technology becomes available to allow a person to voluntarily bar the person's access to receive cash or credit from such devices located on the licensed premises.

(2) A debt transaction greater than \$3 million entered into by a licensee or licensee's parent company assigning an obligation to a licensee, except a debt transaction previously approved in subrule 5.4(20), is subject to commission jurisdiction. The request for approval shall include:

1. The names and addresses of all parties;
2. The amount and source of funds;
3. The nature and amount of security and collateral provided;
4. The specific nature and purpose of the transaction; and
5. The term sheet or executive summary of the transaction.

(3) A qualifying agreement must be submitted within 30 days of execution. Commission approval must be obtained prior to implementation, unless the qualifying agreement contains a written clause stating that the agreement is subject to commission approval. Qualifying agreements need only be submitted on initiation, unless there is a material change in terms or noncompliance with 5.4(8) "b"(4) or to comply with 5.4(8) "a"(1)"3."

b. *Purpose of review.* The commission conducts reviews to serve the public interest to ensure that:

- (1) Gaming is free from criminal and corruptive elements.
- (2) Gaming-related funds are directed to the lawful recipient.
- (3) Gaming profits are not improperly distributed.
- (4) Iowa resources, goods and services are utilized. Resources, goods, and services shall be considered to be made in Iowa, be provided by Iowans, or emanate from Iowa if one or more of the following apply:

1. Goods are manufactured in Iowa.
2. Goods are distributed through a distributor located in Iowa.
3. Goods are sold by a retailer/wholesaler located in Iowa.
4. Resources are produced or processed in Iowa.
5. Services are provided by a vendor whose headquarters/home office is in Iowa.
6. Goods, resources or services are provided by a vendor whose headquarters/home office is located outside Iowa, but which has a tangible business location (not simply a post office box) and does business in Iowa.

7. Services beyond selling are provided by employees who are based in Iowa.

A facility shall be considered to have utilized a substantial amount of Iowa resources, goods, services and entertainment in compliance with Iowa Code sections 99D.9 and 99F.7(4) if the facility demonstrates to the satisfaction of the commission that preference was given to the extent allowed by law and other competitive factors.

*c. Related parties.* Other submittal requirements notwithstanding, agreements negotiated between the facility and a related party must be accompanied by an economic and qualitative justification. For the purpose of this subrule, related party shall mean any one of the following having any beneficial interest in any other party with whom the facility is seeking to negotiate an agreement:

(1) Any corporate officer or member of a facility's board of directors.

(2) Any owner with more than a 5 percent interest in a facility.

(3) A member of either the qualified sponsoring organization or the qualifying organization under Iowa Code section 99D.8 associated with a facility.

*d. Review criteria.* The commission shall approve all qualifying agreements that, in the commission's sole opinion, represent a normal business transaction and may impose conditions on an approval. The commission may deny approval of any agreement that, in the commission's sole opinion, represents a distribution of profits that differs from commission-approved ownership and beneficial interest. This subrule does not prohibit the commission from changing the approved ownership or beneficial interest.

**5.4(9) Checks.** All checks accepted must be deposited in a bank by the close of the banking day following acceptance.

**5.4(10) Taxes and fees.**

*a. Annual taxes and fees.* All taxes and fees, whose collection by the state is authorized under Iowa Code chapters 99D and 99F, shall be accounted for on a fiscal-year basis, each fiscal year beginning on July 1 and ending on June 30.

*b. Submission of gambling game taxes and fees.*

(1) All moneys collected for and owed to the commission or state of Iowa under Iowa Code chapter 99F shall be accounted for and itemized on a weekly basis in a format approved by the commission. Each day on the report shall be an accurate representation of the gaming activities. A week shall begin on Monday and end on Sunday.

(2) The reporting form must be received in the commission office by noon on Wednesday following the week's end. The moneys owed, according to the reporting form, must be received in the treasurer's office by 11 a.m. on the Thursday following the week's end.

(3) Pursuant to Iowa Code section 99F.1(1), taxes from promotional play receipts that are received within the same gaming week but after the date when the limit set forth in the definition of "adjusted gross receipts" is exceeded, as determined by the administrator, will be credited to each facility in the next available gaming week within the same fiscal year.

*c. Calculation of promotional play receipts.* For the purpose of calculating the amount of taxes received from promotional play receipts during a fiscal year, the commission will consider promotional play receipts as taxed in proportion to total adjusted gross receipts for each gaming day.

*d. Submission of sports wagering net receipts taxes.*

(1) A tax is imposed on the sports wagering net receipts received each fiscal year from sports wagering. "Sports wagering net receipts" means the gross receipts less winnings paid to wagerers on sports wagering on a cash accounting basis. Voided and canceled transactions are not considered receipts for the purpose of this calculation. Any offering used to directly purchase a wager shall be considered receipts for the purpose of this calculation.

(2) All moneys collected for and owed to the state of Iowa under Iowa Code chapter 99F for the payment of sports wagering taxes shall be accounted for and itemized on a monthly basis, in a format approved by the commission, by noon on Wednesday following a gaming week's end in which the completed gaming week includes the last day of the month. All sports wagering taxes owed shall be received in the treasurer's office by 11 a.m. on the Thursday after accounting and itemization is due

in the commission office. If sports wagering net receipts for a month are negative, a credit for sports wagering taxes may be given in the subsequent month.

(3) Licensees under Iowa Code section 99F.7 or 99F.7A are responsible for the payment of all sports wagering taxes.

(4) Controls which easily allow for the designation and recording of sports wagering net receipts to an individual licensee and the redemption of winnings to the respective licensee shall be established by the licensee and approved by the administrator.

**5.4(11) Rate of tax revenue.** Each licensee shall prominently display at the licensee's gambling facility the annual percentage rate of state and local tax revenue collected by state and local government from the gambling facility annually.

**5.4(12) Problem gambling.**

*a.* The holder of a license to operate gambling games and the holder of a license to accept simulcast wagering shall adopt and implement policies and procedures designed to:

(1) Identify problem gamblers;

(2) Comply with the process established by the commission to allow a person to be voluntarily excluded from the gaming floor of an excursion gambling boat, from the wagering area as defined in Iowa Code section 99D.2, from the sports wagering area as defined in Iowa Code section 99F.1(24), and from the gaming floor of all other licensed facilities or gambling activities regulated under Iowa Code chapters 99D and 99F; and

(3) Allow persons to be voluntarily excluded for five years or life from all facilities on a form prescribed by the commission. Each facility will disseminate information regarding the exclusion to all other licensees and the commission.

*b.* The policies and procedures shall be developed in cooperation with the gambling treatment program and shall include without limitation the following:

- (1) Training of key employees to identify and report suspected problem gamblers;
- (2) Procedures for recording and tracking identified problem gamblers;
- (3) Policies designed to prevent serving alcohol to intoxicated casino patrons;
- (4) Steps for removing problem gamblers from the casino; and
- (5) Procedures for preventing reentry of problem gamblers.

*c.* A licensee shall include information on the availability of the gambling treatment program in a substantial number of its advertisements and printed materials.

*d.* Money forfeited by a voluntarily excluded person pursuant to Iowa Code sections 99D.7(23) and 99F.4(22) shall be withheld by the licensee and remitted to the general fund of the state by the licensee under Iowa Code chapters 99D and 99F.

**5.4(13) Records regarding ownership.**

*a.* In addition to other records and information required by these rules, each licensee shall maintain the following records regarding the equity structure and owners:

- (1) If a corporation:
  1. A certified copy of articles of incorporation and any amendments thereto.
  2. A copy of bylaws and amendments thereto.
  3. A current list of officers and directors.
  4. Minutes of all meetings of stockholders and directors.
  5. A current list of all stockholders and stockholders of affiliates, including their names and the names of beneficial shareholders.
  6. A complete record of all transfers of stock.
  7. A record of amounts paid to the corporation for issuance of stock and other capital contributions and dates thereof.
  8. A record, by stockholder, of all dividends distributed by the corporation.
  9. A record of all salaries, wages, and other remuneration (including perquisites), direct and indirect, paid by the corporation during the calendar or fiscal year to all officers, directors, and stockholders with an ownership interest at any time during the calendar or fiscal year, equal to or greater than 5 percent of the outstanding stock of any class of stock.

- (2) If a partnership:
  1. A schedule showing the amounts and dates of capital contributions, the names and addresses of the contributors, and percentage of interest in net assets, profits, and losses held by each.
  2. A record of the withdrawals of partnership funds or assets.
  3. A record of salaries, wages, and other remuneration (including perquisites), direct and indirect, paid to each partner during the calendar or fiscal year.
  4. A copy of the partnership agreement and certificate of limited partnership, if applicable.
- (3) If a sole proprietorship:
  1. A schedule showing the name and address of the proprietor and the amount and date of the original investment.
  2. A record of dates and amounts of subsequent additions to the original investment and withdrawals therefrom.
  3. A record of salaries, wages, and other remuneration (including perquisites), direct or indirect, paid to the proprietor during the calendar or fiscal year.
    - b. All records regarding ownership shall be located in a place approved by the commission.
    - c. If the licensee is publicly held, upon the request of the administrator, the licensee shall submit to the commission one copy of any report required to be filed by such licensee or affiliates with the Securities and Exchange Commission or other domestic or foreign securities regulatory agency. If the licensee is privately held, upon the request of the administrator, the licensee shall submit financial, ownership, or other entity records for an affiliate.

**5.4(14) Retention, storage, and destruction of books, records, and documents.**

- a. Except as otherwise provided, all original books, records, and documents pertaining to the licensee's operations shall be:
  - (1) Prepared and maintained in a complete and accurate form.
  - (2) Retained at a site approved by the administrator until audited.
  - (3) Held immediately available for inspection by the commission during business hours of operations.
  - (4) Organized and indexed in such a manner as to provide immediate accessibility to the commission.
    - b. For the purpose of this subrule, "books, records, and documents" shall be defined as any book, record, or document pertaining to or prepared or generated by the licensee including, but not limited to, all forms, reports, accounting records, ledgers, subsidiary records, computer-generated data, internal audit records, correspondence, contracts, and personnel records, including information concerning a refusal to submit to drug testing and test results conducted pursuant to Iowa Code section 730.5.
    - c. All original books, records, and documents may be copied and stored on microfilm, microfiche, or other suitable media system approved by the administrator.
    - d. No original book, record, document, or suitable media copy may be destroyed by a licensee, for three years, without the prior approval of the administrator.
    - e. Any licensee that offers electronic wagering accounts, as defined by rule 491—12.1(99F), must prepare a disaster recovery plan that addresses off-site backups or equivalent. All disaster recovery plans shall incorporate industry standards for retention and storage of wagering account information and shall be subject to review as part of the network security risk assessment required by subrule 5.4(21).

**5.4(15) Remodeling.** For any construction that changes the specific function of a public space of the facility, the licensee must first submit plans to and receive the approval of the administrator.

**5.4(16) Officers, agents, and employees.** Licensees are accountable for the conduct of their officers, agents, and employees. The commission or commission representative reserves the right to impose penalties against the license holder or its officer, agent, employee, or both as the commission or commission representative determines appropriate. In addition, the licensee shall be responsible for the conduct of nonlicensed persons in nonpublic areas of the excursion gambling boat, gambling structure, or racetrack enclosure.

**5.4(17) Designated gaming floor.** The designated gaming floor is all areas occupied by or accessible from a gambling game, not otherwise obstructed by a wall, door, partition, barrier, or patron entrance.

A patron entrance shall be identified by a sign visible to patrons approaching the gaming floor. The sign shall denote entrance to the gaming floor and specify that the gaming floor is not accessible to persons under the age of 21. A floor plan identifying the area shall be filed with the administrator for review and approval. Modification to a previously approved plan must be submitted for approval at least ten days prior to implementation.

**5.4(18) State fire and building codes.**

*a.* Barges, as defined in 5.6(1)“c,” and other land-based gaming facilities and such facilities that undergo major renovation shall comply with the state building code created by Iowa Code chapter 103A, if there is no local building code in force in the local jurisdiction in which the facility is located. A licensee shall submit construction documents and plans to the state building code commissioner and receive approval prior to construction, if a facility is subject to the state building code.

*b.* If there is no enforcement of fire safety requirements by a local fire department, a licensee shall also submit construction plans and documents to the state fire marshal and receive approval prior to construction. The fire marshal may cause a facility subject to this paragraph to be inspected for compliance with fire marshal rules prior to operation of the facility and shall notify the commission and the licensee of the results of any such inspection.

*c.* If a proposed new or renovated facility is subject to both paragraphs “a” and “b,” a single submission of construction plans and documents to the building code commissioner, with a cover letter stating that review and approval are required with respect to both the state building code and rules of the fire marshal, is sufficient to meet both requirements. Facilities subject to both paragraphs “a” and “b” shall have received approval from both the fire marshal and the building code commissioner prior to construction.

**5.4(19) Gambling setoff.** Each licensee shall adopt and implement policies and procedures designed to set off winnings of patrons who have a valid lien established under Iowa Code chapters 99D and 99F.

**5.4(20) Shelf application for debt.**

*a.* The commission may grant approval of a shelf application for a period not to exceed three years.

*b.* Licensees whose parent company has issued publicly traded debt or publicly traded securities may apply to the commission for a shelf approval of debt transactions if the parent company has:

(1) A class of securities listed on the New York Stock Exchange, the American Stock Exchange or the National Association of Securities Dealers Automatic Quotation System (NASDAQ) or has stockholders’ equity in the amount of \$15 million or more as reported in the parent company’s most recent report on Form 10-K or Form 10-Q filed with the Securities and Exchange Commission (SEC) immediately preceding application; and

(2) Filed all reports required by the SEC.

*c.* The application shall be in writing and shall contain:

(1) Proof of qualification to make the application in accordance with the criteria of this subrule.

(2) A statement of the amount of debt sought to be approved and the intended use of potential proceeds.

(3) Duration sought for the shelf approval.

(4) Financing rate sought during shelf approval.

(5) Evidence of signature by authorized representative of the licensee under oath.

(6) Other supplemental documentation requested by the commission or commission representative following the initial submission.

*d.* Once an application is approved by the commission:

(1) The licensee shall notify the commission representative of all debt transactions within ten days of consummation, including subsequent amendments and modifications of debt transactions, and provide executed copies of the documents evidencing the transactions as may be required.

(2) The commission representative may rescind a shelf approval without prior written notice. The rescission shall be in writing and set forth the reasons for the rescission and shall remain in effect until lifted by the commission upon the satisfaction of any such terms and conditions as required by the commission.

**5.4(21) Network security.**

a. The licensee shall biennially submit the results of an independent network security risk assessment to the administrator for review, subject to the following requirements:

(1) The testing organization must be independent of the licensee and shall be qualified by the administrator.

(2) The network security risk assessment shall be conducted no later than 90 days after the start of the licensee's fiscal year in each year an assessment is required.

(3) Results from the network security risk assessment shall be submitted to the administrator no later than 90 days after the assessment is conducted.

b. At the discretion of the administrator, additional network security risk assessments may be required.

**5.4(22) Cashless wagering reserves.** A reserve in the form of cash or cash equivalents segregated from operational funds shall be maintained to cover the entirety of a licensee's electronic wagering account liability. The reserve shall equal or exceed the licensee's wagering account liability as of the last day in the previous quarter. An accounting of this reserve shall be made available for inspection to the commission upon request. The method of reserve shall be submitted to and approved by the administrator prior to implementation.

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#### **491—5.5(99D) Pari-mutuel uniform requirements.**

**5.5(1) Insect and rodent control.** The licensee shall provide systematic and effective insect and rodent control, including control of flies, mosquitoes, fleas, and mice, to all areas of licensee's premises at all times during a race meeting.

**5.5(2) Results boards, totalizators required.** Each licensee shall provide and maintain computerized totalizators and electronic boards showing odds, results, and other racing information located in plain view of patrons.

**5.5(3) Photo finish camera.** A licensee shall provide two electronic photo finish devices with mirror image to photograph the finish of each race and record the time of each racing animal in at least hundredths of a second. The location and operation of the photo finish device must be approved by the commission before its first use in a race. The licensee shall promptly post a photograph, on a monitor, of each photo finish for win, place or show, or for fourth place in superfecta races, in an area accessible to the public. The licensee shall ensure that the photo finish devices are calibrated before the first day of each race meeting and at other times as required by the commission. On request by the commission, the licensee shall provide, without cost, a print of a photo finish to the commission. A photo finish of each race shall be maintained by the licensee for not less than six months after the end of the race meeting, or such other period as may be requested by the commission.

**5.5(4) Electric timing device.** Any electric timing device used by the licensee shall be approved by the commission.

**5.5(5) Official scale.** The licensee shall provide and maintain in good working order official scales or other approved weighing devices. The licensee shall provide to the stewards certification of the accuracy of the scales at the beginning of each race meeting or more frequently if requested by the stewards.

**5.5(6) Lighting.** Each licensee shall provide and maintain adequate illumination in the barn/kennel area, parking area, and racetrack area.

**5.5(7) Fencing.** The stable and kennel areas should be properly fenced as defined by the commission and admission permitted only in accord with rules of the commission.

**5.5(8) Guest passes.** The licensee shall develop a policy to be approved by the stewards for the issuance of guest passes for entrance to the kennel or stable area. The guest pass is not an occupational license and does not permit the holder to work in any capacity or in any way confer the benefits of an occupational license to participate in racing. The license holder sponsoring or escorting the guest shall be responsible for the conduct of the guest pass holder.

**5.5(9) Stewards.** There shall be three stewards for each racing meet, two appointed by the commission and one nominated by the licensee for approval by the commission. The names of licensees' nominees for steward and biographical information describing the experience and qualifications of the nominees shall be submitted no later than 45 days before commencement of a race meeting. The commission may consider for appointment or approval a person who meets all of the following requirements. The person shall have:

- a. Engaged in pari-mutuel racing in a capacity and for a period satisfactory to the commission.
- b. Satisfactorily passed an optical examination within one year prior to approval as a steward evidencing corrected 20/20 vision and the ability to distinguish colors correctly.
- c. Satisfied the commission that income, other than salary as a steward, is independent of and unrelated to patronage of or employment by any occupational licensee under the supervision of the steward, so as to avoid the appearance of any conflict of interest or suggestion of preferential treatment of an occupational licensee.

**5.5(10) Purse information.** Each licensee shall provide to the commission at the close of each racing meet the following purse information:

- a. The identity of each person or entity to which purse money is paid by the licensee for purses won by racing animals at the facility. This report shall include the name, residential or business address and amount paid to that person or entity. The data should be assembled separately for Iowa and non-Iowa addressees, and aggregates should be presented in descending order of magnitude.
- b. The identity of each person or entity to which purse money is paid by the licensee for purses won by Iowa-bred animals at the facility. This report shall include the name, residential or business address and amount paid to that person or entity in supplemental funds for ownership of Iowa-bred animals. The data should be assembled separately for Iowa and non-Iowa addressees, and aggregates should be presented in descending order of magnitude.

**5.5(11) Designated wagering area.** The designated wagering area is an area of a racetrack, designated by a licensee and approved by the commission, in which a licensee may receive from a person wagers of money on a horse or dog in a race selected by the person making the wagers as designated by the commission. Modification to a previously approved plan must be submitted for approval at least ten days prior to implementation. Exceptions to this rule must be approved in writing by the commission.

**5.5(12) Mobile pari-mutuel wagering.** Pari-mutuel wagering shall be allowed outside the designated wagering area using mobile pari-mutuel tellers with portable wagering devices and by any other method approved in writing by the commission.

[ARC 2927C, IAB 2/1/17, effective 3/8/17; ARC 3608C, IAB 1/31/18, effective 3/7/18; ARC 4378C, IAB 3/27/19, effective 5/1/19]

#### **491—5.6(99F) Excursion gambling boat uniform requirements.**

##### **5.6(1) Excursion gambling boat.**

- a. *Capacity.* The minimum passenger capacity necessary for an excursion gambling boat is 250.
- b. *Excursion boat.* A self-propelled, floating "vessel" as defined by the U.S. Coast Guard may contain more than one vessel. In order to be utilized for gaming purposes, the vessel containing the casino must either contain a permanent means of propulsion or have its means of propulsion contained in an attached vessel. In the event that the vessel containing the casino is propelled by a second vessel, the boat will be considered self-propelled only when the vessels are designed, constructed, and operated as a single unit.

- c. *Moored barge.* "Barge" means any stationary structure approved by the commission, where the entire gaming floor is located on or near a body of water as defined under Iowa Code section 99F.7, subsection 1, and which facility is subject to land-based building codes rather than maritime or Iowa department of natural resources inspection laws and regulations.

##### **5.6(2) Excursions.**

- a. *Length.* The excursion season shall be from April 1 through October 31 of each calendar year. An excursion boat must operate at least one excursion during the excursion season to operate during the off-season, although a waiver may be granted by the commission in the first year of a boat's operation

if construction of the boat was not completed in time for the boat to qualify. Excursions shall consist of a minimum of one hour in transit during the excursion season. The number of excursions per day is not limited. During the excursion season and the off-season, while the excursion gambling boat is docked, passengers may embark or disembark at any time during business hours pursuant to Iowa Code section 99F.4(17).

*b. Dockside completion of excursions.* If, during the excursion season, the captain determines that it would be unsafe to complete any portion of an excursion, or if mechanical problems prevent the completion of any portion of an excursion, the boat may be allowed to remain at the dock or, if the excursion is underway, return to the dock and conduct the gaming portion of the excursion while dockside, unless the captain determines that passenger safety is threatened.

*c. Notification.* If an excursion is not completed due to reasons specified in paragraph 5.6(2) “b,” a commission representative shall be notified as soon as is practical.

**5.6(3) Drug testing of boat operators.** Captains, pilots, and physical operators of excursion gambling boats shall be drug tested, as permitted by Iowa Code section 730.5, on a continuous basis with no more than 60 days between tests. The testing shall be conducted by a laboratory certified by the United States Department of Health and Human Services or approved under the rules adopted by the Iowa department of public health. The facility shall report positive test results to a commission representative.

These rules are intended to implement Iowa Code chapters 99D and 99F.

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CHAPTER 8  
PARI-MUTUEL WAGERING, SIMULCASTING AND ADVANCE DEPOSIT WAGERING

[Prior to 11/19/86, Racing Commission[693]]  
[Prior to 11/18/87, Racing and Gaming Division[195]]

**491—8.1(99D) Definitions.**

“*Account*” means an account approved by the commission for pari-mutuel advance deposit wagering with a complete record of credits, wagers and debits established by a licensee account holder and managed by a licensee or ADWO.

“*Administrator*” means the administrator of the Iowa racing and gaming commission or the administrator’s designee.

“*Advance deposit wagering*” means a method of pari-mutuel wagering in which an individual may establish an account, deposit money into the account, and use the account balance to pay for pari-mutuel wagering.

“*Advance deposit wagering center*” means an actual location, the equipment, and the staff of a licensee, ADWO, or both involved in the management, servicing and operation of the pari-mutuel advance deposit wagering for the licensee.

“*Advance deposit wagering operator*” or “*ADWO*” means an advance deposit wagering operator licensed by the commission who has entered into an agreement with the licensee of the horse racetrack in Polk County and the Iowa Horsemen’s Benevolent and Protective Association to provide pari-mutuel advance deposit wagering.

“*Authorized receiver*” means a receiver that conducts and operates a pari-mutuel wagering system on the results of contests being held or conducted and simulcast from the enclosures of one or more host facilities.

“*Betting interest*” means a number assigned to a single runner, an entry or a field for wagering purposes.

“*Board of stewards*” means a board established by the administrator to review conduct by pari-mutuel facilities and their employees that may constitute violations of the rules and statutes relating to pari-mutuel racing. The administrator may serve as a board of one.

“*Breakage*” means the odd cents by which the amount payable on each dollar wagered in a pari-mutuel pool exceeds a multiple of ten cents. “*Breakage*” is the net pool minus payoff.

“*Commission*” means the Iowa racing and gaming commission.

“*Commission representative*” means an employee of the commission designated to represent the commission in matters pertaining to the operation of the mutuel department. In the absence of a specifically appointed representative, a commission steward will perform the functions and duties of the commission representative.

“*Contest*” means a race on which wagers are placed.

“*Credits*” means all positive inflows of money to an account.

“*Dead heat*” means that two or more runners have tied at the finish line for the same position in the order of finish.

“*Debits*” means all negative outflow of money from an account.

“*Deposit*” means a payment of money into an account.

“*Double*” means a wager to select the winners of two consecutive races and is not a parlay and has no connection with or relation to any other pool conducted by the facility and shall not be construed as a “quinella double.”

“*Entry*” means two or more runners are coupled in a contest because of common ties and a wager on one of them shall be a wager on all of them.

“*Exacta*” (may also be known as “*perfecta*” or “*correcta*”) means a wager selecting the exact order of finish for first and second in that contest and is not a parlay and has no connection with or relation to any other pool conducted by the facility.

“*Facility*” means an entity licensed by the commission to conduct pari-mutuel wagering in Iowa.

“*Field*” means when the individual runners competing in a contest exceed the numbering capacity of the totalizator and all runners of the higher number shall be grouped together. A wager on one in the field shall be a wager on all. (No “fields” shall be allowed in greyhound racing.)

“*Guest facility*” means a facility which offers licensed pari-mutuel wagering on contests conducted by another facility (the host) in either the same state or another jurisdiction.

“*Host facility*” means the facility conducting a licensed pari-mutuel meeting from which authorized contests or entire performances are simulcast.

“*Interstate simulcasting*” means the telecast of live audio and visual signals of pari-mutuel racing sent to or received from a state outside the state of Iowa to an authorized racing or gaming facility for the purpose of wagering.

“*Intrastate simulcasting*” means the telecast of live audio and visual signals of pari-mutuel racing conducted on a licensed pari-mutuel track within Iowa sent to or received from an authorized pari-mutuel facility within Iowa for the purpose of pari-mutuel wagering.

“*Licensee*” means a horse racetrack located in Polk County operating under a license issued by the commission.

“*Licensee account holder*” means any individual at least 21 years of age who successfully completed an application and for whom the licensee or ADWO has opened an account. “Licensee account holder” does not include any corporation, partnership, limited liability company, trust, estate or other formal or nonformal entity.

“*Minus pool*” means when the total amount of money to be returned to the public exceeds what is in the pool because of the deduction of a commission and because of the rule stipulation that no mutuel tickets shall be paid at less than \$1.05 for each \$1.00 wagered.

“*Mutuel department*” means that area of a racetrack where wagers are made and winning tickets are cashed and where the totalizator is installed and any area used directly in the operation of pari-mutuel wagering.

“*Mutuel manager*” means an employee of the facility who manages the mutuel department.

“*Net pool*” means the amount remaining in each separate pari-mutuel pool after the takeout percentage, as provided for by Iowa Code section 99D.11, has been deducted.

“*Odds*” means the approximate payoffs per dollar based on win pool wagering only on each betting interest for finishing first without a dead heat with another betting interest.

“*Official*” means that the order of finish for the race is “official” and that payoff prices based upon the “official” order of finish shall be posted.

“*Order of finish*” means the finishing order of each runner from first place to last place in each race. For horse racing only, the order of finish may be changed by the stewards for a rule infraction prior to posting of the official order of finish.

“*Pari-mutuel pool*” means the total amount of money wagered on each separate pari-mutuel pool for payoff purposes.

“*Payoff*” means the amount distributed to holders of valid winning pari-mutuel tickets in each pool as determined by the official order of finish and includes the amount wagered and profit.

“*Place*” means a runner finishing second.

“*Place pool*” means the total amount of money wagered on all betting interests in each race to finish first or second.

“*Post time*” means the scheduled starting time for a contest.

“*Proper identification*” means a form of identification accepted in the normal course of business to establish that the person making a transaction is a licensee account holder.

“*Quinella*” means a wager selecting two runners to finish first and second, regardless of the order of finish, and is not a parlay and has no connection with or relation to any other pool conducted by the facility.

“*Quinella double*” means a wager which consists of selecting the quinella in each of two designated contests and is an entirely separate pool from all other pools and has no connection with or relation to any other pool conducted by the facility.

“*Runner*” means each entrant in a contest, designated by a number as a betting interest.

“*Sales transaction data*” means the data between totalizator ticket-issuing machines and the totalizator central processing unit for the purpose of accepting wagers and generating, canceling and cashing pari-mutuel tickets and the financial information resulting from the processing of sales transaction data, such as handle.

“*Secure personal identification code*” means an alpha-numeric character code provided by a licensee account holder as a means by which the licensee or ADWO may verify a wager or account transaction as authorized by the licensee account holder.

“*Show*” means a runner finishing third.

“*Show pool*” means the total amount of money wagered on all betting interests in each contest to finish either first, second or third.

“*Source market fee*” or “*host fee*” means the part of a wager that is made on any race by a person who is a licensee account holder and that is returned to the licensee and the Iowa Horsemen’s Benevolent and Protective Association pursuant to the terms of a negotiated agreement as required by 491—8.6(99D).

“*Steward*” means a racing official appointed or approved by the commission to perform the supervisory and regulatory duties relating to pari-mutuel racing.

“*Superfecta*” means a wager selecting the exact order of finish for first, second, third, and fourth in that contest and is not a parlay and has no connection with or relation to any other pool conducted by the facility.

“*Totalizator*” means a machine for registering wagers and computing odds and payoffs based upon data supplied by each pari-mutuel ticket-issuing machine.

“*Trifecta*” means a wager selecting the exact order of finish for first, second, and third in that race and is not a parlay and has no connection with or relation to any other pool conducted by the facility.

“*Tri-superfecta*” means a wager selecting the exact order of finish for first, second and third in the first designated tri-super contest combined with selecting the exact order of finish for first, second, third and fourth in the second designated tri-super contest.

“*Twin quinella*” means a wager in which the bettor selects the first two finishers, regardless of order, in each of two designated contests. Each winning ticket for the twin quinella must be exchanged for a free ticket on the second twin quinella contest in order to remain eligible for the second-half twin quinella pool.

“*Twin superfecta*” means a wager in which the bettor selects the first four finishers, in their exact order, in each of two designated contests. Each winning ticket for the first twin superfecta contest must be exchanged for a free ticket on the second twin superfecta contest in order to remain eligible for the second-half twin superfecta pool.

“*Twin trifecta*” means a wager in which the bettor selects the three runners that will finish first, second, and third in the exact order as officially posted in each of the two designated twin trifecta races.

“*Underpayment*” means when the payoff to the public resulting from errors in calculating pools and errors occurring in the communication in payoffs results in less money returned to the public than is actually due.

“*Win*” means a runner finishing first.

“*Win pool*” means the total amount wagered on all betting interests in each contest to finish first.

“*Withdrawal*” means a payment of money from an account by the licensee or ADWO to the licensee account holder when properly requested by the licensee account holder.

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#### **491—8.2(99D) General.**

**8.2(1) Wagering.** Each facility shall conduct wagering in accordance with applicable laws and these rules. Such wagering shall employ a pari-mutuel system approved by the commission. The totalizator shall be tested prior to and during the meeting as required by the commission. Annually, the facility shall have an external audit, approved by the administrator, of the totalizator system. All systems of wagering other than pari-mutuel, such as bookmaking and auction-pool selling, are prohibited, and any person attempting to participate in prohibited wagering shall be ejected or excluded from facility grounds.

**8.2(2) Records.** The facility shall maintain records of all wagering so the commission may review such records for any contest including the opening line, subsequent odds fluctuation, the amount and at which window wagers were placed on any betting interest and such other information as may be required. Such wagering records shall be retained by each facility and safeguarded for a period of time specified by the commission. The commission may require that certain of these records be made available to the wagering public at the completion of each contest.

The facility shall provide the commission with a list of the licensed individuals afforded access to pari-mutuel records and equipment at the wagering facility.

**8.2(3) Pari-mutuel tickets.** A pari-mutuel ticket is evidence of a contribution to the pari-mutuel pool operated by the facility and is evidence of the obligation of the facility to pay to the holder thereof such portion of the distributable amount of the pari-mutuel pool as is represented by such valid pari-mutuel ticket. The facility shall cash all valid winning tickets when such are presented for payment during the course of the meeting where sold and for a specified period after the last day of the meeting as provided in paragraph 8.2(4) "g."

*a.* To be deemed a valid pari-mutuel ticket, such ticket shall have been issued by a pari-mutuel ticket machine operated by the facility and recorded as a ticket entitled to a share of the pari-mutuel pool and contain imprinted information as to:

- (1) The name of the facility operating the meeting.
- (2) A unique identifying number or code.
- (3) Identification of the terminal at which the ticket was issued.
- (4) A designation of the performance for which the wagering transaction was issued.
- (5) The contest number for which the pool is conducted.
- (6) The type(s) of wagers represented.
- (7) The number(s) representing the betting interests for which the wager is recorded.
- (8) The amount(s) of the contributions to the pari-mutuel pool or pools for which the ticket is evidence.

*b.* No pari-mutuel ticket recorded or reported as previously paid, canceled, or nonexistent shall be deemed a valid pari-mutuel ticket by the facility. The facility may withhold payment and refuse to cash any pari-mutuel ticket deemed not valid, except as provided in paragraph 8.2(4) "e."

**8.2(4) Pari-mutuel ticket sales.**

*a.* Pari-mutuel tickets shall not be sold by anyone other than a facility licensed to conduct pari-mutuel wagering.

*b.* No pari-mutuel ticket may be sold on a contest for which wagering has already been closed, and no facility shall be responsible for ticket sales entered into but not completed by issuance of a ticket before the totalizator is closed for wagering on such contest.

*c.* Claims pertaining to a mistake on an issued or unissued ticket must be made by the bettor prior to leaving the seller's window.

*d.* Payment on winning pari-mutuel wagers shall be made on the basis of the order of finish as purposely posted and declared "official." Any subsequent change in the order of finish or award of purse money(s) as may result from a subsequent ruling by the stewards or administrator shall in no way affect the pari-mutuel payoff. If an error in the posted order of finish or payoff figures is discovered, the official order of finish or payoff prices may be corrected and an announcement concerning the change shall be made to the public.

*e.* The facility shall not satisfy claims on lost, mutilated, or altered pari-mutuel tickets without authorization from the administrator.

*f.* The facility shall have no obligation to enter a wager into a betting pool if unable to do so due to equipment failure.

*g.* Payment on valid pari-mutuel tickets shall be made only upon presentation and surrender to the facility where the wager was made within 60 days following the close of the meeting during which the

wager was made. Failure to present any such ticket within 60 days shall constitute a waiver of the right to receive payment.

**8.2(5) *Advance performance wagering.*** No facility shall permit wagering to begin more than one hour before scheduled post time of the first contest of a performance unless it has first obtained the authorization of the administrator.

**8.2(6) *Claims for payment from pari-mutuel pool.*** At a designated location, a written, verified claim for payment from a pari-mutuel pool shall be accepted by the facility in any case where the facility has withheld payment or has refused to cash a pari-mutuel wager. The claim shall be made on such form as approved by the administrator, and the claimant shall make such claim under penalty of perjury. The original of such claim shall be forwarded to the administrator within 48 hours.

*a.* In the case of a claim made for payment of a mutilated pari-mutuel ticket which does not contain the total imprinted elements required in paragraph 8.2(3) “*a*” of these general provisions, the facility shall make a recommendation to accompany the claim forwarded to the administrator as to whether or not the mutilated ticket has sufficient elements to be positively identified as a winning ticket.

*b.* In the case of a claim made for payment on a pari-mutuel wager, the administrator shall adjudicate the claim and may order payment thereon from the pari-mutuel pool or by the facility, may deny the claim, or may make such other order as the administrator may deem proper.

**8.2(7) *Payment for errors.*** If an error occurs in the payment amounts for pari-mutuel wagers which are cashed or entitled to be cashed, and as a result of such error the pari-mutuel pool involved in the error is not correctly distributed among winning ticket holders, the following shall apply:

*a.* Verification is required to show that the amount of the commission, the amount in breakage, and the amount in payoffs are equal to the total gross pool. If the amount of the pool is more than the amount used to calculate the payoff, the underpayment shall be added to the corresponding pool of the next contest. If an underpayment is discovered after the close of the meeting, the underpayment shall be held in an interest-bearing account approved by the administrator until being added, together with accrued interest, to the corresponding pool of the next meet.

*b.* Any claim not filed with the facility within 30 days, inclusive of the date on which the underpayment was publicly announced, shall be deemed waived, and the facility shall have no further liability therefor.

*c.* In the event the error results in an overpayment to winning wagers, the facility shall be responsible for such payment.

**8.2(8) *Betting explanation.*** A summary explanation of pari-mutuel wagering and each type of betting pool offered shall be published in the program for every wagering performance. The rules of racing relative to each type of pari-mutuel pool offered must be prominently displayed on facility grounds and available upon request through facility representatives.

**8.2(9) *Display of betting information.***

*a.* Approximate odds for win pool betting shall be posted on display devices within view of the wagering public and updated at intervals of not more than 90 seconds.

*b.* The probable payoff or amounts wagered, in total and on each betting interest, for other pools may be displayed to the wagering public at intervals and in a manner approved by the administrator.

*c.* Official results and payoffs must be displayed upon each contest being declared official.

**8.2(10) *Canceled contests.*** If a contest is canceled or declared “no contest,” refunds shall be granted on valid wagers in accordance with these rules.

**8.2(11) *Refunds.***

*a.* Notwithstanding other provisions of these rules, refunds of the entire pool shall be made on:

(1) Win pools, exacta pools, and first-half double pools offered in contests in which the number of betting interests has been reduced to fewer than two.

(2) Place pools, quinella pools, trifecta pools, first-half quinella double pools, first-half twin quinella pools, first-half twin trifecta pools, and first-half tri-superfecta pools offered in contests in which the number of betting interests has been reduced to fewer than three.

(3) Show pools, superfecta pools, and first-half twin superfecta pools offered in contests in which the number of betting interests has been reduced to fewer than four.

b. Authorized refunds shall be paid upon presentation and surrender of the affected pari-mutuel ticket.

**8.2(12) *Coupled entries and mutuel fields.***

a. Contestants coupled in wagering as a coupled entry or mutuel field shall be considered part of a single betting interest for the purpose of price calculations and distribution of pools. Should any contestant in a coupled entry or mutuel field be officially withdrawn or scratched, the remaining contestants in that coupled entry or mutuel field shall remain valid betting interests and no refunds will be granted. If all contestants within a coupled entry or mutuel field are scratched, then tickets on such betting interests shall be refunded, notwithstanding other provisions of these rules.

b. For the purpose of price calculations only, coupled entries and mutuel fields shall be calculated as a single finisher, using the finishing position of the leading contestant in that coupled entry or mutuel field to determine order of placing. This rule shall apply to all circumstances, including situations involving a dead heat, except as otherwise provided by these rules.

**8.2(13) *Pools dependent upon betting interests.*** Unless the administrator otherwise provides, at the time the pools are opened for wagering, the facility:

a. May offer win, place, and show wagering on all contests with six or more betting interests.

b. May prohibit show wagering on any contest with five or fewer betting interests scheduled to start.

c. May prohibit place wagering on any contest with four or fewer betting interests scheduled to start.

d. May prohibit quinella wagering on any contest with three or fewer betting interests scheduled to start.

e. May prohibit quinella double wagering on any contests with three or fewer betting interests scheduled to start.

f. May prohibit exacta wagering on any contest with three or fewer betting interests scheduled to start.

g. May prohibit trifecta wagering on any contest with five or fewer betting interests scheduled to start, or as provided in subparagraph 8.2(13) "g"(1) below:

(1) Cancel trifecta. The stewards have the authority to cancel trifecta wagering at any time they determine an irregular pattern of wagering or determine that the conduct of the race would not be in the interest of the regulation of the pari-mutuel wagering industry or in the public confidence in racing. The stewards may approve smaller fields for trifecta wagering if extraneous circumstances are shown by the facility.

(2) Reserved.

h. May prohibit superfecta wagering on any contest with seven or fewer betting interests scheduled to start.

i. May prohibit twin quinella wagering on any contests with three or fewer betting interests scheduled to start.

j. May prohibit twin trifecta wagering on any contests with seven or fewer betting interests scheduled to start, except as provided in subparagraph 8.2(13) "g"(1).

k. May prohibit tri-superfecta wagering on any contests with seven or fewer betting interests scheduled to start.

l. May prohibit twin superfecta wagering on any contests with seven or fewer betting interests scheduled to start.

**8.2(14) *Prior approval required for betting pools.***

a. A facility that desires to offer new forms of wagering must apply in writing to the administrator and receive written approval prior to implementing the new betting pool.

b. The facility may suspend previously approved forms of wagering with the prior approval of the administrator. Any carryover shall be held until the suspended form of wagering is reinstated. A facility may request approval of a form of wagering or separate wagering pool for specific requirements.

**8.2(15) *Closing of wagering in a contest.***

a. All wagering shall stop and all pari-mutuel machines shall be locked at post time or at the actual start of the races. Machines shall be automatically locked, unless unusual circumstances dictate that the stewards act differently.

b. The facility shall maintain, in good order, a system approved by the administrator for closing wagering.

**8.2(16) Complaints pertaining to pari-mutuel operations.**

a. When a patron makes a complaint to a facility regarding the mutuel department, the facility shall immediately issue a complaint report, setting out:

- (1) The name of the complainant;
- (2) The nature of the complaint;
- (3) The name of the persons, if any, against whom the complaint was made;
- (4) The date of the complaint;
- (5) The action taken or proposed to be taken, if any, by the facility.

b. The facility shall submit every complaint report to the commission within five days after the complaint was made.

**8.2(17) Facility/vendor employees.** All facility/vendor employees shall report immediately to the administrator any known irregularities or wrongdoings by any person involving pari-mutuel wagering and shall cooperate in subsequent investigations.

**8.2(18) Unrestricted access.** The facility shall permit the commission unrestricted access at all times to its facilities and equipment and to all books, ledgers, accounts, documents and records of the facility that relate to pari-mutuel wagering.

**8.2(19) Totalizator breakdown.** In the event of irreparable breakdown of the totalizator during the wagering on a race, the wagering on that race shall be declared closed and the payoff shall be computed on the sums wagered in each pool up to the time of the breakdown.

**8.2(20) Minimum wager and payoff.** The minimum wager to be accepted by any licensed facility for win, place and show wagering shall be \$2. The minimum payoff on a \$2 wager shall be \$2.10. For all other wagers, the minimum wager to be accepted by any licensed facility shall be \$1. The minimum payoff for a \$1 wager shall be \$1.05. Any deviation from these minimums must be approved by the administrator. In cases where a minus pool occurs, the facility is responsible for the payment of the minimum payoff and no breakage shall be incurred from that pari-mutuel pool.

**8.2(21) Underage wagering prohibited.** No person under the age of 21 shall be permitted by any licensed facility to purchase or cash a pari-mutuel ticket.

**8.2(22) Emergency situations.** In the event of an emergency in connection with the mutuel department not covered in these rules, the pari-mutuel manager representing the facility shall report the problem to the stewards, and the stewards shall render a full report to the administrator or administrator's designee within 48 hours.

**8.2(23) Commission mutuel supervisor.** The commission may employ a mutuel supervisor with accounting experience to serve as the commission's designated representative at each race meeting as provided in Iowa Code section 99D.19. In the absence of a specifically appointed commission mutuel supervisor, the board of stewards or simulcast steward will perform the functions and duties of the commission.

[ARC 0734C, IAB 5/15/13, effective 6/19/13; ARC 1876C, IAB 2/18/15, effective 3/25/15; ARC 3608C, IAB 1/31/18, effective 3/7/18; ARC 5422C, IAB 2/10/21, effective 3/17/21]

**491—8.3(99D) Approval of pari-mutuel wagers.**

**8.3(1) Pools permitted.** All pari-mutuel wagering pools approved by the commission shall be separately and independently calculated and distributed. Takeout shall be deducted from each gross pool as stipulated by Iowa Code section 99D.11. The remainder of the moneys in the pool shall constitute the net pool for distribution as payoff on winning wagers.

**8.3(2) Pari-mutuel wagering submissions.** Prior to conducting a new pari-mutuel wager, a facility shall submit proposals for the wager including, but not limited to, the wager type, calculation of payoff, refunds and distribution of pools. The wager submission, or requests for modification to an approved

wager, shall be in writing and approved by the administrator or an administrator's designee prior to implementation.

**8.3(3) Public notice.** The public shall have access to the wagering rules and the calculation of payoffs and distribution of pools which are approved by the commission. Signage shall be conspicuously posted in the wagering area to direct patrons to the wagering area where this information can be viewed.  
[ARC 0734C, IAB 5/15/13, effective 6/19/13]

#### **491—8.4(99D) Simulcast wagering.**

##### **8.4(1) General.**

*a. Rules.* All simulcasting must be transmitted live, and all wagering on simulcasting shall be made in accordance with the commission rules on pari-mutuel wagering. Commission rules in effect during live racing shall remain in effect during simulcasting where applicable.

*b. Transmission.* The method used to transmit sales transaction and data including, but not limited to, the odds, will pay, race results, and payoff prices must be approved by the commission, based upon the determination that provisions to secure the system and transmission are satisfactory. If the method relies on Internet service to transmit, a backup Internet service shall be used in the event of transmission failure until all transactions are completed for the day.

*c. Communication.* A communication system between the host track and the receiving facility must be provided which will allow the totalizator operator and the commission representatives at the host track to communicate with the facility receiving the signal. The facility is responsible during the racing program's operating hours for reporting any problems or delays to the public.

##### *d. Approval.*

(1) All simulcasting, both interstate and intrastate, must be preapproved by the commission or commission representative. Each facility conducting simulcasting shall submit an annual written simulcast proposal to the commission with the application for license renewal required by 491—Chapter 1.

(2) The commission representative, upon written request, may grant modifications to the annual simulcast proposal. The commission representative may approve or disapprove simulcast requests at the representative's discretion. Factors that may be considered include, but are not limited to, economic conditions of a facility, impact on other facilities, impact on the Iowa breeding industry, other gambling in the state, and any other considerations the commission representative deems appropriate.

(3) Once simulcast authority has been granted by the commission or commission representative, it shall be the affirmative responsibility of the facility granted simulcast authority to obtain all necessary permission from other states and tracks to simulcast the pari-mutuel races. In addition, the burden of adhering to state and federal laws concerning simulcasting rests on the facility at all times.

##### **8.4(2) Simulcast host.**

*a.* Every host facility, if requested, may contract with an authorized receiver for the purpose of providing authorized users its simulcast. All contracts governing participation in interstate or intrastate pools shall be submitted to the commission representative for prior approval. Contracts shall be of such content and in such format as required by the commission representative.

*b.* A host facility is responsible for the content of the simulcast and shall use all reasonable effort to present a simulcast which offers the viewers an exemplary depiction of each performance.

*c.* Unless otherwise permitted by the commission representative, every simulcast will contain in its video content a digital display of actual time of day, the name of the host facility from which the simulcast originates, the number of the contest being displayed, and any other relevant information available to patrons at the host facility.

*d.* The host facility shall maintain such security controls, including encryption over its uplink and communications systems, as directed or approved by the commission or commission representative.

*e.* Financial reports shall be submitted daily or as otherwise directed by the commission representative. Reports shall be of such content and in such format as required by the commission representative.

##### **8.4(3) Authorized receiver.**



- d.* Rules established in the state of the host facility designated for a pari-mutuel pool shall apply.
- e.* The commission representative shall approve agreements made between the facility and other participants in interstate common pools governing the distribution of breakage between the jurisdictions.
- f.* If, for any reason, it becomes impossible to successfully merge the bets placed into the interstate common pool, the facility shall make payoffs in accordance with payoff prices that would have been in effect if prices for the pool of bets were calculated without regard to wagers placed elsewhere, except that, with the permission of the commission representative, the facility may alternatively determine either to pay winning tickets at the payoff prices at the host facility or to declare such accepted bets void and make refunds in accordance with the applicable rules.

**8.5(3)** *Host state participation in merged pools.*

*a.* With the prior approval of the commission representative, a facility licensed to conduct pari-mutuel wagering may determine that one or more of its contests be utilized for pari-mutuel wagering at guest facilities in other states and may also determine that pari-mutuel pools in guest states be combined with corresponding wagering pools established by it as the host facility or comparable wagering pools established by two or more states.

*b.* When takeout rates in the merged pool are identical, the net-price calculation shall be the method by which the differing takeout rates are applied.

*c.* Rules of racing established for races held in this state shall also apply to interstate common pools unless the commission representative specifically determines otherwise.

*d.* The commission representative shall approve agreements made between the facility and other participants in interstate common pools governing the distribution of breakage between the jurisdictions.

*e.* Any contract for interstate common pools entered into by the facility shall contain a provision to the effect that if, for any reason, it becomes impossible to successfully merge the bets placed in another state into the interstate common pool formed by the facility or if, for any reason, the commission representative or facility determines that attempting to effect transfer of pool data from the guest state may endanger the facility's wagering pool, the facility shall have no liability for any measure taken which may result in the guest's wagers not being accepted into the pool.

**8.5(4)** *Takeout rates in interstate common pools.*

*a.* With the prior approval of the commission representative, a facility wishing to participate in an interstate common pool may change its takeout rate so as to achieve a common takeout rate with all other participants in the interstate common pool.

*b.* A facility wishing to participate in an interstate common pool may request that the commission representative approve a methodology whereby host facility and guest facility states with different takeout rates for corresponding pari-mutuel pools may effectively and equitably combine wagers from the different states into an interstate common pool.

[ARC 0734C, IAB 5/15/13, effective 6/19/13]

**491—8.6(99D) Advance deposit wagering.**

**8.6(1)** *Authorization to conduct advance deposit wagering.*

*a.* A licensee may request authorization from the commission to conduct advance deposit wagering pursuant to Iowa Code section 99D.11(6) "c" and these rules. As part of the request, the licensee shall submit a detailed plan of how its advance deposit wagering system would operate. The commission may require changes in a proposed plan of operations as a condition of granting a request. No subsequent changes in the system's operation may occur unless ordered by the commission or until approval is obtained from the commission after it receives a written request.

*b.* The commission may conduct investigations or inspections or request additional information from the licensee as the commission deems appropriate in determining whether to allow the licensee to conduct advance deposit wagering.

*c.* The licensee shall establish and manage an advance deposit wagering center.

*d.* The commission may issue an ADWO license to an entity that enters into an agreement with the commission, the licensee, and the Iowa Horsemen's Benevolent and Protective Association. The terms of any ADWO's license shall include but not be limited to:

- (1) Any source market fees and host fees to be paid on any races subject to advance deposit wagering.
- (2) An annual ADWO license fee in an amount to be determined by the commission.
- (3) Completion of all necessary background investigations.
- (4) Acceptance of wagers on live races conducted at the horse racetrack in Polk County from all of its licensee account holders.
- (5) A bond or irrevocable letter of credit on behalf of the ADWO to be determined by the commission.
- (6) A detailed description and certification of systems and procedures used by the ADWO to validate the identity and age of licensee account holders and to validate the legality of wagers accepted.
- (7) Certification of prompt commission access to all records relating to licensee account holder identity and age in hard-copy or standard electronic format acceptable to the commission.
- (8) Certification of secure retention of all records related to advance deposit wagering and accounts for a period of not less than three years or such longer period as specified by the commission.
- (9) Utilization and communication of pari-mutuel wagers to a pari-mutuel system meeting all requirements for pari-mutuel systems employed by licensed racing facilities in Iowa.

*e.* Commission access to and use of information concerning advance deposit wager transactions and licensee account holders shall be considered proprietary, and such information shall not be disclosed publicly except as may be required pursuant to statute or court order or except as part of the official record of any proceeding before the commission. This requirement shall not prevent the sharing of this information with other pari-mutuel regulatory authorities or law enforcement agencies for investigative purposes.

*f.* For each advance deposit wager made for an account by telephone, the licensee or ADWO shall make a voice recording of the entire transaction and shall not accept any such wager if the voice-recording system is inoperable. Voice recordings shall be retained for not less than six months and shall be made available to the commission for investigative purposes.

**8.6(2) *Establishing an account.***

*a.* A person must have an established account in order to place advance deposit wagers. An account may be established in person at the licensee's facility or with the ADWO by mail or electronic means. For establishing an account, the application must be signed or otherwise authorized in a manner acceptable to the commission and shall include the applicant's full legal name, principal residence address, telephone number, and date of birth and any other information required by the commission. The licensee and ADWO shall have a process to verify that the player is not on the statewide self-exclusion list set forth in Iowa Code section 99F.4(22) prior to establishing an account. The licensee and ADWO shall review and deactivate accounts of newly enrolled participants of the statewide self-exclusion program and comply with all other requirements set forth by the commission and in Iowa Code section 99F.4(22).

*b.* Each application submitted will be subject to electronic verification with respect to the applicant's name, principal residence address and date of birth by either a national, independent individual reference service company or by means of a technology which meets or exceeds the reliability, security, accuracy, privacy and timeliness provided by individual reference service companies. An applicant's social security number may be necessary for completion of the verification process and for tax-reporting purposes. If there is a discrepancy between the application submitted and the information provided by the electronic verification or if no information on the applicant is available from such electronic verification, another individual reference service may be accessed or another technology meeting the requirements described above may be used to verify the information provided. If these measures prove unsatisfactory, then the applicant will be contacted and given instructions as to how to resolve the matter.

*c.* The identity of a licensee account holder must be verified via electronic means or copies of other documents before the licensee account holder may place an advance deposit wager.

*d.* Each account shall have a unique identifying account number. The identifying account number may be changed at any time by the licensee or ADWO provided that the licensee or ADWO informs the licensee account holder in writing prior to the change.

*e.* The applicant shall provide the licensee or ADWO with an alpha-numeric code to be used as a secure personal identification code when the licensee account holder is placing an advance deposit wager. The licensee account holder has the right to change this code at any time.

*f.* The licensee account holder shall receive at the time the account is approved a unique account identification number; a copy of the advance deposit wagering rules and such other information and material pertinent to the operation of the account; and such other information as the licensee, ADWO or commission may deem appropriate.

*g.* The account is nontransferable.

*h.* The licensee or ADWO may close or refuse to open an account for what it deems good and sufficient reason and shall order an account closed if it is determined that information used to open an account was false or that the account has been used in violation of these rules or the licensee's or ADWO's terms and conditions.

**8.6(3) Operation of an account.** The ADWO shall submit operating procedures with respect to licensee account holder accounts for commission approval.

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CHAPTER 10  
THOROUGHBRED AND QUARTER HORSE RACING

**491—10.1(99D) Terms defined.** As used in the rules, unless the context otherwise requires, the following definitions apply:

“*Age*” means the age of a horse reckoned from the first day of January of the year of foaling.

“*Allowance race*” means an overnight race for which eligibility and weight to be carried are determined according to specified conditions that include age, sex, earnings, and number of wins.

“*Also eligible*” means:

1. A number of eligible horses, properly entered, which were not drawn for inclusion in a race but which become eligible according to preference or lot when an entry is scratched prior to the scratch time deadline; or

2. The next preferred nonqualifier for the finals or consolation from a set of elimination trials that will become eligible in the event a finalist is scratched by the stewards for a rule violation or is otherwise eligible if written race conditions permit.

“*Appeal*” means a request for the commission or its designee to investigate, consider, and review any decisions or rulings of stewards.

“*Arrears*” means all moneys owed by a licensee, including subscriptions, jockey fees, forfeitures, and any default incident to these rules.

“*Authorized agent*” means a person licensed by the commission and appointed by a written instrument, signed and acknowledged before a notary public by the owner on whose behalf the agent will act.

“*Bleeder*” means a horse that hemorrhages from within the respiratory tract during a race, within one and one-half hours postrace, during exercise or within one and one-half hours of exercise.

“*Bleeder list*” means a tabulation of all bleeders to be maintained by the commission.

“*Chemist*” means any official racing chemist designated by the commission.

“*Claiming race*” means a race in which any horse starting may be claimed (purchased for a designated amount) in conformance with the rules. (See also waived claiming rule in paragraph 10.6(18)“k.”)

“*Commission*” means the racing and gaming commission.

“*Conditions*” means qualifications that determine a horse’s eligibility to be entered in a race.

“*Contest*” means a competitive racing event on which pari-mutuel wagering is conducted.

“*Coupled entry*” means two or more contestants in a contest that are treated as a single betting interest for pari-mutuel wagering purposes. (See also “Entry.”)

“*Day*” means a 24-hour period ending at midnight.

“*Dead heat*” means when the noses of two or more horses reach the finish line of a race at the same time.

“*Declaration*” means the act of withdrawing an entered horse from a race prior to the closing of entries.

“*Detention barn*” means the barn designated for the collection from horses of test samples under the supervision of the commission veterinarian; also the barn assigned by the commission to a horse on the bleeder list, for occupancy as a prerequisite for receiving bleeder medication.

“*Entry*” means a horse made eligible to run in a race; or two or more horses, entered in the same race, which have common ties of ownership, lease, or training. (See also “Coupled entry.”)

“*Facility*” means an entity licensed by the commission to conduct pari-mutuel wagering or gaming operations in Iowa.

“*Facility premises*” means all real property utilized by the facility in the conduct of its race meeting, including the racetrack, grandstand, concession stands, offices, barns, stable area, employee housing facilities, parking lots, and any other areas under the jurisdiction of the commission.

“*Field or mutuel field*” means a group of two or more horses upon which a single bet may be placed. A mutuel field is required when the number of horses starting in a race exceeds the capacity of the track

totalizator. The highest numbered horse within the totalizator capacity and all the higher-numbered horses following are then grouped together in the mutuel field.

*“Foreign substances”* means all substances except those that exist naturally in the untreated horse at normal physiological concentration.

*“Forfeit”* means money due from a licensee because of an error, fault, neglect of duty, breach of contract, or penalty imposed by the stewards or the commission.

*“Handicap”* means a race in which the weights to be carried by the horses are assigned by the racing secretary or handicapper for the purpose of equalizing the chances of winning for all horses entered.

*“Horse”* means any equine (including equine designated as a mare, filly, stallion, colt, ridgeling, or gelding) registered for racing; specifically, an entire male 5 years of age and older.

*“Hypodermic injection”* means any injection into or under the skin or mucosa, including intradermal injection, subcutaneous injection, submucosal injection, intramuscular injection, intravenous injection, intra-arterial injection, intra-articular injection, intrabursal injection, and intraocular (intraconjunctival) injection.

*“Inquiry”* means an investigation by the stewards of potential interference in a contest prior to declaring the result of said contest official.

*“Jockey”* means a professional rider licensed to ride in races.

*“Licensee”* means any person or entity licensed by the commission to engage in racing or related regulated activity.

*“Maiden race”* means a contest restricted to nonwinners.

*“Meet/meeting”* means the specified period and dates each year during which a facility is authorized by the commission to conduct pari-mutuel wagering on horse racing.

*“Month”* means a calendar month.

*“Nomination”* means the naming of a horse to a certain race or series of races generally accompanied by payment of a prescribed fee.

*“Nominator”* means the person or entity in whose name a horse is nominated for a race or series of races.

*“Objection”* means:

1. A written complaint made to the stewards concerning a horse entered in a race and filed not later than one hour prior to the scheduled post time of the first race on the day in which the questioned horse is entered; or

2. A verbal claim of foul in a race lodged by the horse’s jockey, trainer, owner, or the owner’s authorized agent before the race is declared official.

*“Official starter”* means the official responsible for dispatching the horses for a race.

*“Official time”* means the elapsed time from the moment the first horse crosses the starting point until the first horse crosses the finish line.

*“Overnight race,”* also known as a purse race, means a contest for which entries close at a time set by the racing secretary.

*“Owner”* means a person or entity that holds any title, right or interest, whole or partial, in a horse, including the lessee and lessor of a horse.

*“Paddock”* means an enclosure in which horses scheduled to compete in a contest are saddled prior to racing.

*“Performance”* means a schedule of 8 to 12 races per day unless otherwise authorized by the commission.

*“Post position”* means the preassigned position from which a horse will leave the starting gate.

*“Post time”* means the scheduled time for horses to arrive at the starting gate for a contest.

*“Prize”* means the combined total of any cash, premium, trophy, and object of value awarded to the owners of horses according to order of finish in a race.

*“Purse”* means the total cash amount for which a race is contested.

*“Purse race”* means a race for money or other prize to which the owners of horses entered do not contribute money toward its purse.

“*Race*” means a running contest between horses ridden by jockeys for a purse, prize, or other reward run at a facility in the presence of the stewards of the meeting. This includes purse races, overnight races and stakes races.

“*Recognized meeting*” means any meeting with regularly scheduled races for horses on the flat in a jurisdiction having reciprocal relations with this state and the commission for the mutual enforcement of rulings relating to horse racing.

“*Rules*” means the rules promulgated by the commission to regulate the conduct of horse racing.

“*Scratch*” means the act of withdrawing an entered horse from a contest after the closing of entries.

“*Scratch time*” means the deadline set by the facility for withdrawal of entries from a scheduled performance.

“*Smoke*” means the procedure of reviewing entries for correctness, eligibility, weight allowances, and medications.

“*Stakes race*” means a contest in which nomination (if applicable), entry, and starting fees contribute to the purse. No overnight race shall be considered a stakes race. Special designations or classifications for stakes races such as “graded stakes” or “black type” shall be determined by the appropriate breed registries or recognized authorities.

“*Starter*” means a horse that becomes an actual contestant in a race by virtue of the starting gate opening in front of it upon dispatch by the official starter.

“*Steward*” means a duly appointed racing official with powers and duties specified by rules.

“*Subscription*” means moneys paid for nomination, entry, eligibility, or starting of a horse in a stakes race.

“*Test level*” means the concentration of a foreign substance found in the test sample.

“*Test sample*” means any bodily substance including, but not limited to, blood, urine, or hair taken from a horse under the supervision of the commission veterinarian and as prescribed by the commission for the purpose of analysis.

“*Totalizator*” means the system used for recording, calculating, and disseminating information about ticket sales, wagers, odds, and payoff prices to patrons at a pari-mutuel wagering facility.

“*Veterinarian*” means a veterinarian holding a current unrestricted license issued by the state of Iowa veterinary regulatory authority and licensed by the commission.

“*Winner*” means the horse whose nose reaches the finish line first or is placed first through disqualification by the stewards.

“*Year*” means a calendar year.

[ARC 9987B, IAB 2/8/12, effective 3/14/12; ARC 2468C, IAB 3/30/16, effective 5/4/16; ARC 4194C, IAB 12/19/18, effective 1/23/19]

#### **491—10.2(99D) Facilities’ responsibilities.**

**10.2(1) *Stalls.*** The facility shall ensure that racing animals are stabled in individual box stalls; that the stables and immediate surrounding area are maintained in approved sanitary condition at all times; that satisfactory drainage is provided; and that manure and other refuse are kept in separate boxes or containers at locations distant from living quarters and promptly and properly removed.

**10.2(2) *Paddocks and equipment.*** The facility shall ensure that paddocks, starting gates, and other equipment subject to contact by different animals are kept in a clean condition and free of dangerous surfaces.

**10.2(3) *Receiving barn and stalls.*** Each facility shall provide a conveniently located receiving barn or stalls for the use of horses arriving during the meeting. The barn shall have adequate stable room and facilities, hot and cold water, and stall bedding. The facility shall employ attendants to operate and maintain the receiving barn or stalls in a clean and healthy condition.

**10.2(4) *Fire protection.*** The facility shall develop and implement a program for fire prevention on facility premises in accordance with applicable state fire codes. The facility shall instruct employees working on facility premises in procedures for fire prevention and evacuation. The facility shall, in accordance with state fire codes, prohibit the following:

- a. Smoking in horse stalls, feed and tack rooms, and in the alleyways.

- b. Sleeping in feed rooms or stalls.
- c. Open fires and oil- or gasoline-burning lanterns or lamps in the stable area.
- d. Leaving any electrical appliance unattended or in unsafe proximity to walls, beds, or furnishings.
- e. Keeping flammable materials, including cleaning fluids or solvents, in the stable area.
- f. Locking a stall which is occupied by a horse.

The facility shall post a notice in the stable area which lists the prohibitions outlined in 10.2(4) "a" to "f" above.

**10.2(5) Starting gate.**

- a. During racing hours a facility shall provide at least two operable padded starting gates that have been approved by the commission.
- b. During designated training hours a facility shall make at least one starting gate and qualified starting gate employee available for schooling.
- c. If a race is started at a place other than in a chute, the facility shall provide and maintain in good operating condition backup equipment for moving the starting gate. The backup equipment must be immediately available to replace the primary moving equipment in the event of failure.

**10.2(6) Distance markers.**

- a. A facility shall provide and maintain starting point markers and distance poles in a size and position that can be clearly seen from the steward's stand.
- b. The starting point markers and distance poles must be marked as follows:

1/4 poles	red and white horizontal stripes
1/8 poles	green and white horizontal stripes
1/16 poles	black and white horizontal stripes
220 yards	green and white
250 yards	blue
300 yards	yellow
330 yards	black and white
350 yards	red
400 yards	black
440 yards	red and white
550 yards	black and white horizontal stripes
660 yards	green and white horizontal stripes
770 yards	black and white horizontal stripes
870 yards	blue and white horizontal stripes

**10.2(7) Detention enclosure.** Each facility shall maintain a detention enclosure for use by the commission for securing samples of urine, saliva, blood, hair, or other bodily substances or tissues for chemical analysis from horses that have run in a race. The enclosure shall include a wash rack, commission veterinarian office, a walking ring, at least four stalls, workroom for the sample collectors with hot and cold running water, and glass observation windows for viewing of the horses from the office and workroom. An owner, trainer, or designated representative licensed by the commission shall be with a horse in the detention barn at all times.

**10.2(8) Ambulance.** A facility shall maintain, on the premises during every day that its track is open for racing or exercising, an ambulance for humans and an ambulance for horses, equipped according to prevailing standards and staffed by medical doctors, paramedics, or other personnel trained to operate them. When an ambulance is used for transfer of a horse or patient to medical facilities, a replacement ambulance must be furnished by the facility to comply with this rule.

**10.2(9) Helmets and vests.** Any person on horseback on facility grounds shall wear a protective helmet and safety vest.

*a.* A jockey participating in a race shall have a helmet that is not altered and complies with one of the following standards:

- (1) American Society for Testing and Materials (ASTM 1163).
- (2) European Standards (EN-1384 or PAS-015 or VG1).
- (3) Australian/New Zealand Standards (AS/NZ 3838).
- (4) ARB HS 2012.
- (5) Snell Equestrian Standard 2001.

*b.* A jockey participating in a race shall have a vest that is not altered and complies with one of the following minimum safety standards:

- (1) British Equestrian Trade Association (BETA) 2000 Level 1.
- (2) Euro Norm (EN) 13158:2000 Level 1.
- (3) American Society for Testing and Materials (ASTM) F2681-08 or F1937.
- (4) Shoe and Allied Trade Research Association (SATRA) Jockey Vest Document M6 Issue 3.
- (5) Australian Racing Board (ARB) Standard 1.1998.

**10.2(10) Racetrack.**

*a.* The surface of a racetrack, including cushion, subsurface, and base, must be designed, constructed, and maintained to provide for the safety of the jockeys and racing animals.

*b.* Distances to be run shall be measured from the starting line at a distance three feet out from the inside rail.

*c.* A facility shall provide an adequate drainage system for the racetrack.

*d.* A facility shall provide adequate equipment and personnel to maintain the track surface in a safe training and racing condition. The facility shall provide backup equipment for maintaining the track surface. A facility that conducts races on a turf track shall:

- (1) Maintain an adequate stockpile of growing medium; and
- (2) Provide a system capable of adequately watering the entire turf course evenly.

*e.* Rails.

(1) Racetracks, including turf tracks, shall have inside and outside rails, including gap rails, designed, constructed, and maintained to provide for the safety of jockeys and horses. The design and construction of rails must be approved by the commission prior to the first race meeting at the track.

(2) The top of the rail must be at least 38 inches but not more than 44 inches above the top of the cushion. The inside rail shall have no less than a 24-inch overhang with a continuous smooth cover.

(3) All rails must be constructed of materials designed to withstand the impact of a horse running at a gallop.

**10.2(11) Patrol films or video recordings.** Each facility shall provide:

*a.* A video recording system approved by the commission. Cameras must be located to provide clear panoramic and head-on views of each race. Separate monitors, which simultaneously display the images received from each camera and are capable of simultaneously displaying a synchronized view of the recordings of each race for review, shall be provided in the stewards' stand. The location and construction of video towers must be approved by the commission.

*b.* One camera, designated by the commission, to record the prerace loading of all horses into the starting gate and to continue to record until the field is dispatched by the starter.

*c.* One camera, designated by the commission, to record the apparent winner of each race from the finish line until the horse has returned, the jockey has dismounted, and the equipment has been removed from the horse.

*d.* At the discretion of the stewards, video camera operators to record the activities of any horses or persons handling horses prior to, during, or following a race.

*e.* That races run on an oval track be recorded by at least three video cameras. Races run on a straight course must be recorded by at least two video cameras.

*f.* Upon request of the commission, without cost, a copy of a video recording of a race.

g. That video recordings recorded prior to, during, and following each race be maintained by the facility for not less than six months after the end of the race meeting, or such other period as may be requested by the stewards or the commission.

h. A viewing room in which, on approval by the stewards, an owner, trainer, jockey, or other interested individual may view a video recording of a race.

i. Following any race in which there is an inquiry or objection, the video recorded replays of the incident in question which were utilized by the stewards in making their decision. The facility shall display to the public these video recorded replays on designated monitors.

**10.2(12) Communications.**

a. Each facility shall provide and maintain in good working order a communication system between:

- (1) The stewards' stand;
- (2) The racing office;
- (3) The tote room;
- (4) The jockeys' room;
- (5) The paddock;
- (6) The test barn;
- (7) The starting gate;
- (8) The weigh-in scale;
- (9) The video camera locations;
- (10) The clocker's stand;
- (11) The racing veterinarian;
- (12) The track announcer;
- (13) The location of the ambulances (equine and human); and
- (14) Other locations and persons designated by the commission.

b. A facility shall provide and maintain a public address system capable of clearly transmitting announcements to the patrons and to the stable area.

[ARC 2468C, IAB 3/30/16, effective 5/4/16; ARC 4194C, IAB 12/19/18, effective 1/23/19; ARC 5423C, IAB 2/10/21, effective 3/17/21]

**491—10.3(99D) Facility policies.** It shall be the affirmative responsibility and continuing duty of each occupational licensee to follow and comply with the facility policies as published in literature distributed by the facility or posted in a conspicuous location.

**491—10.4(99D) Racing officials.**

**10.4(1) General description.** Every facility conducting a race meeting shall appoint at least the following officials:

- a. One of the members of a three-member board of stewards;
- b. Racing secretary;
- c. Assistant racing secretary;
- d. Paddock judge;
- e. Horse identifier;
- f. Starter;
- g. Clocker/timer;
- h. Three placing judges;
- i. Jockey room custodian;
- j. Mutuel manager;
- k. Clerk of scales;
- l. Minimum of two outriders;
- m. Horsemen's bookkeeper;
- n. Any other person designated by the commission.

**10.4(2) Officials' prohibited activities.** No racing official or racing official's assistant(s) listed in 10.4(1) while serving in that capacity during any meeting may engage in any of the following:

- a. Enter into a business or employment that would be a conflict of interest, interfere with, or conflict with the proper discharge of duties including a business that does business with a facility or a business issued a concession operator's license;
- b. Participate in the sale, purchase, or ownership of any horse racing at the meeting;
- c. Be involved in any way in the purchase or sale of any contract on any jockey racing at the meeting;
- d. Sell or solicit horse insurance on any horse racing at the meeting, or any other business sales or solicitation not a part of the official's duties;
- e. Wager on the outcome of any race under the jurisdiction of the commission;
- f. Accept or receive money or anything of value for the official's assistance in connection with the official's duties;
- g. Consume or be under the influence of alcohol or any prohibited substance while performing official duties.

**10.4(3) *Single official appointment.*** No official appointed to any meeting, except placing judges, may hold more than one official position listed in 10.4(1) unless, in the determination of the stewards or commission, the holding of more than one appointment would not subject the official to a conflict of interest or duties in the two appointments.

**10.4(4) *Stewards.*** (For practice and procedure before the stewards and the commission, see 491—Chapter 4.)

a. *General authority.*

(1) General. The board of stewards for each racing meet shall be responsible to the commission for the conduct of the racing meet in accordance with the laws of this state and the rules adopted by the commission. The stewards shall have authority to regulate and to resolve conflicts or disputes between all other racing officials, licensees, and those persons addressed by 491—paragraph 4.6(5) "e," which are reasonably related to the conduct of a race or races and to discipline violators of these rules in accordance with the provisions of these rules.

(2) Period of authority. The stewards' authority as set forth in this subrule shall commence 30 days prior to the beginning of each racing meet and shall terminate 30 days after the end of each racing meet or with the completion of their business pertaining to the meeting.

(3) Attendance. All three stewards shall be present in the stand during the running of each race.

(4) Appointment of substitute. Should any steward be absent at race time, the state steward(s) shall appoint a deputy for the absent steward. If any deputy steward is appointed, the commission shall be notified immediately by the stewards.

(5) Initiate action. The stewards shall take notice of questionable conduct or rule violations, with or without complaint, and shall initiate investigations promptly and render a decision on every objection and every complaint made to them.

(6) General enforcement provisions. Stewards shall enforce the laws of Iowa and the rules of the commission. The laws of Iowa and the rules of racing apply equally during periods of racing. They supersede the conditions of a race and the regulations of a racing meet and, in matters pertaining to racing, the orders of the stewards supersede the orders of the officers of the facility. The decision of the stewards as to the extent of a disqualification of any horse in any race shall be final.

b. *Other powers and authority.*

(1) The stewards shall have the power to interpret the rules and to decide all questions not specifically covered by them.

(2) All questions within their authority shall be determined by a majority of the stewards.

(3) The stewards shall have control over and access to all areas of the facility premises.

(4) The stewards shall have the authority to determine all questions arising with reference to entries and racing. Persons entering horses to run at licensed facilities agree in so doing to accept the decision of the stewards on any questions relating to a race or racing. The stewards, in their sole discretion, are authorized to determine whether two or more individuals or entities are operating as a single financial interest or as separate financial interests. In making this determination, the stewards shall consider all relevant information including, but not limited to, the following:

1. Whether the parties pay bills from and deposit receipts in the same accounts.
  2. Whether the parties share resources such as employees, feed, supplies, veterinary and farrier services, exercise and pony riders, tack, and equipment.
  3. Whether the parties switch horses or owner/trainer for no apparent reason, other than to avoid restrictions of being treated as a single interest.
  4. Whether the parties engage in separate racing operations in other jurisdictions.
  5. Whether the parties have claimed horses, or transferred claimed horses after the fact, for the other's benefit.
  6. If owners, whether one owner is paying the expenses for horses not in the owner's name as owner.
  7. If trainers, whether the relationship between the parties is more consistent with that of a trainer and assistant trainer.
- (5) The stewards shall have the authority to discipline, for violation of the rules, any person subject to their control and, in their discretion, to impose fines or suspensions or both for infractions.
  - (6) The stewards shall have the authority to order the exclusion or ejection from all premises and enclosures of the facility any person who is disqualified for corrupt practices on any race course in any country.
  - (7) The stewards shall have the authority to call for proof that a horse is itself not disqualified in any respect, or nominated by, or, wholly or in part, the property of, a disqualified person. In default of proof being given to their satisfaction, the stewards may declare the horse disqualified.
  - (8) The stewards shall have the authority at any time to order an examination of any horse entered for a race or which has run in a race.
  - (9) In order to maintain necessary safety and health conditions and to protect the public confidence in horse racing as a sport, the stewards have the authority to authorize a person(s) on their behalf to enter into or upon the buildings, barns, motor vehicles, trailers, or other places within the premises of a facility, to examine same, and to inspect and examine the person, personal property, and effects of any person within such place, and to seize any illegal articles or any items as evidence found.
  - (10) The stewards shall maintain a log of all infractions of the rules and of all rulings of the stewards upon matters coming before them during the race meet.
  - (11) The state stewards must give prior approval for any person other than the commissioners or commission representative to be allowed in the stewards' stand.
- c. Emergency authority.*
- (1) Substitute officials. When in an emergency, any official is unable to discharge the official's duties, the stewards may approve the appointment of a substitute and shall report it immediately to the commission.
  - (2) Substitute jockeys. The stewards have the authority, in an emergency, to place a substitute jockey on any horse in the event the trainer does not do so. Before using that authority, the stewards shall in good faith attempt to inform the trainer of the emergency and to afford the trainer the opportunity to appoint a substitute jockey. If the trainer cannot be contacted, or if the trainer is contacted but fails to appoint a substitute jockey and inform the stewards of the substitution by 30 minutes prior to post time, then the stewards may appoint under this rule.
  - (3) Substitute trainer. The stewards have the authority in an emergency to designate a substitute trainer for any horse.
  - (4) Excuse horse. In case of accident or injury to a horse or any other emergency deemed by the stewards before the start of any race, the stewards may excuse the horse from starting.
  - (5) Exercise authority. No licensee may exercise a horse on the track between races unless upon the approval of the stewards.
  - (6) Nonstarter. At the discretion of the stewards, any horse(s) precluded from having a fair start may be declared a nonstarter, and any wagers involving said horse(s) may be ordered refunded.
- d. Investigations and decisions.*
- (1) Investigations. The stewards may, upon direction of the commission, conduct inquiries and shall recommend to the commission the issuance of subpoenas to compel the attendance of witnesses

and the production of reports, books, papers, and documents for any inquiry. The commission stewards have the power to administer oaths and examine witnesses. The stewards shall submit a written report to the commission of every such inquiry made by them.

(2) Form reversal. The stewards shall take notice of any marked reversal of form by any horse and shall conduct an inquiry of the horse's owner, trainer, or other persons connected with the horse including any person found to have contributed to the deliberate restraint or impediment of a horse in order to cause it not to win or finish as near as possible to first.

(3) Fouls.

1. Extent of disqualification. Upon any claim of foul submitted to them, the stewards shall determine the extent of any disqualification and place any horse found to be disqualified behind others in the race with which it interfered or may place the offending horse last in the race. The stewards at their discretion may determine if there was sufficient interference or intimidation to affect the outcome of the race and take the appropriate actions thereafter.

2. Jockey guilty of foul. The stewards may discipline any jockey whose horse has been disqualified as a result of a foul committed during the running of a race.

(4) Protests and complaints. The stewards shall investigate promptly and render a decision in every protest and complaint made to them. They shall keep a record of all protests and complaints and any rulings made by the stewards and shall file reports daily with the commission.

1. Involving fraud. Protests involving fraud may be made by any person at any time. The protest must be made to the stewards.

2. Not involving fraud. Protests, except those involving fraud, may be filed only by the owner of a horse, authorized agent, trainer, or the jockey of the horse in the race over which the protest is made. The protest must be made to the clerk of scales, the stewards, or a person designated by the stewards before the race is declared official. If the placement of the starting gate is in error, no protest may be made, unless entered prior to the start of the race.

3. Protest to clerk of scales. A jockey who intends to enter a protest following the running of any race, and before the race is declared official, shall notify the clerk of scales, or a person designated by the stewards, of this intention immediately upon the arrival of the jockey at the scales.

4. Prize money of protested horse. During the time of determination of a protest, any money or prize won by a horse protested or otherwise affected by the outcome of the race shall be paid to and held by the horsemen's bookkeeper until the protest is decided.

5. Protest in writing. A protest, other than one arising out of the actual running of a race, must be in writing, signed by the complainant, and filed with the stewards not later than one hour before post time of the race out of which the protest arises.

6. Frivolous protests. No person shall make a frivolous protest nor may any person withdraw a protest without the permission of the stewards.

*e. Cancel wagering.* The stewards have the authority to cancel wagering on an individual betting interest or on an entire race and also have the authority to cancel a pari-mutuel pool for a race or races if such action is necessary to protect the integrity of pari-mutuel wagering.

**10.4(5) Racing secretary.**

*a. General authority.* The racing secretary is responsible for setting the conditions for each race of the meeting, regulating the nomination of entries, determining the amounts of purses and to whom they are due, and recording of race results. The racing secretary shall permit no person other than licensed racing officials to enter the racing secretary's office or work areas until such time as all entries are closed, drawn, and smoked. Exceptions to this rule must be approved by the stewards.

*b. Conditions.* The racing secretary shall establish the conditions and eligibility for entering the races of the meeting and cause them to be published to owners, trainers, and the commission. Corrections to the conditions must be made before entries are taken.

*c. Posting of entries.* Upon the closing of entries each day, the racing secretary shall post a list of entries in a conspicuous location in the office of the racing secretary and shall furnish that list to local newspaper, radio, and television stations.



Distance	Age	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	Five Years and Up	126	126	126	126	126	126	126	126	126	126	126	126
	Two Years	X	X	X	X	X	X	X	X	X	X	X	X
TWO MILES	Three Years	96	96	102	102	106	109	112	114	117	119	120	120
	Four Years	124	124	126	126	126	126	126	125	125	124	124	124
	Five Years and Up	126	126	126	126	126	126	126	125	125	124	124	124

## (2) Weights listed.

1. In races of intermediate lengths, the weights for the shorter distance shall be carried.
2. In a race exclusively for two-year-olds, the weight shall be 122 pounds.
3. In a race exclusively for three-year-olds or four-year-olds, the weight shall be 126 pounds.

## (3) Minimum weight.

1. Thoroughbreds. In all overnight races for two-year-olds, three-year-olds, or four-year-olds and older, the minimum weight shall be 112 pounds, subject to sex and apprentice allowance. This rule shall not apply to handicaps or to races written for three-year-olds and older.

2. Quarter horse and mixed races. In all overnight races for two-year-olds, the weight shall be 120 pounds; for three-year-olds, the weight shall be 122 pounds; and for four-year-olds and older, the weight shall be 124 pounds.

3. Quarter horse and mixed races. In qualifying for a speed index, standard weight shall be 120 pounds. Should any horse carry less than this amount in a race, one-tenth of a second will be added to the official time for each four pounds or fraction thereof less than 120 pounds.

(4) Sex allowances. In thoroughbred racing, sex allowances are obligatory. Sex allowances shall be applied in all thoroughbred races unless the conditions of the race expressly state to the contrary. If the conditions of the race are silent as to sex allowances, a sex allowance shall be applied. Sex allowances may not be declined. Two-year-old fillies shall be allowed three pounds; mares three years old and older are allowed five pounds before September 1 and three pounds thereafter. Sex allowances are not applicable for quarter horse or mixed races.

(5) Iowa-foaled horse allowance. Iowa-foaled horses that are properly registered and whose papers are stamped, physically or digitally, by the Iowa department of agriculture and land stewardship shall be allowed an additional three pounds beyond the stated conditions of the race if the race is not limited to Iowa-foaled horses. This allowance does not apply to stakes races.

*h. Penalties not cumulative.* Penalties and weight allowances are not cumulative unless so declared in the conditions of a race by the racing secretary.

*i. Winnings.*

(1) All inclusive. For the purpose of the setting of conditions by the racing secretary, winnings shall be considered to include all moneys and prizes won up to the time of the start of a race, including those races outside the United States. Foreign winnings shall be determined on the basis of the normal rate of exchange prevailing on the day of the win. The amount of purse money earned is credited in United States currency, and there shall be no appeal for any loss on the exchange rate at the time of transfer from United States currency to that of another country.

(2) Winnings considered from January 1. Winnings during the year shall be reckoned by the racing secretary from the preceding January 1.

(3) Winner of a certain sum. "Winner of a certain sum" means the winner of a single race of that sum, unless otherwise expressed in the condition book by the racing secretary. In determining the net value to the winner of any race, the sums contributed by its owner or nominator shall be deducted from the amount won. In all stakes races, the winnings shall be computed on the value of the gross earnings.

(4) Winner's award. Rescinded IAB 5/16/01, effective 6/20/01.

*j. Cancellation of a race.* The racing secretary has the authority to withdraw, cancel, or change any race which has not been closed. In the event the race is canceled, any and all fees paid in connection with the race shall be refunded.

*k. Coggins test.* The racing secretary shall ensure that all horses have a current negative Coggins test. The racing secretary shall report all expired certificates to the stewards.

*l. Registrations and supporting documents.* The racing secretary shall be responsible for receiving, inspecting, and safeguarding all registrations and supporting documents submitted by the trainer while the horses are located on facility premises. Upon notification from a trainer of an alteration of the sex of a horse, the racing secretary shall note such alteration on the certificate of registration. Disclosure is made for the benefit of the public and all documents pertaining to the ownership or lease of a horse filed with the racing secretary shall be available for public inspection.

**10.4(6) Paddock judge.**

*a. General authority.* The paddock judge shall:

- (1) Supervise the assembly of horses in the paddock no later than 15 minutes before the scheduled post time for each race;
- (2) Maintain a written record of all equipment, inspect all equipment of each horse saddled, and report any change thereof to the stewards;
- (3) Prohibit any change of equipment without the approval of the stewards;
- (4) Ensure that the saddling of all horses is orderly, open to public view, free from public interference, and that horses are mounted at the same time and leave the paddock for the post in proper sequence;
- (5) Supervise paddock schooling of all horses approved for such by the stewards;
- (6) Report to the stewards any observed cruelty to a horse; and
- (7) Ensure that only properly authorized persons are permitted in the paddock.

*b. Paddock judge's list.*

- (1) The paddock judge shall maintain a list of horses which shall not be entered in a race because of poor or inconsistent behavior in the paddock that endangers the health or safety of other participants in racing.
- (2) At the end of each day, the paddock judge shall provide a copy of the list to the stewards.
- (3) To be removed from the paddock judge's list, a horse must be schooled in the paddock and demonstrate to the satisfaction of the paddock judge and the stewards that the horse is capable of performing safely in the paddock.

**10.4(7) Horse identifier.** The horse identifier shall:

- a.* When required, ensure the safekeeping of registration certificates and racing permits for horses stabled or racing on facility premises;
- b.* Inspect documents of ownership, eligibility, registration, or breeding necessary to ensure the proper identification of each horse scheduled to compete at a race meeting;
- c.* Examine every starter in the paddock for sex, color, markings, microchip, lip tattoo, or digital tattoo for comparison with its registration certificate to verify the horse's identity;
- d.* Supervise the tattooing, digital tattooing, microchipping or branding for identification of any horse located on facility premises; and
- e.* Report to the stewards any horse not properly identified or whose registration certificate is not in conformity with these rules.

**10.4(8) Starter.**

*a. General authority.* The starter shall:

- (1) Have complete jurisdiction over the starting gate, the starting of horses, and the authority to give orders not in conflict with the rules as may be required to ensure all participants an equal opportunity to a fair start;
- (2) Appoint and supervise assistant starters who have demonstrated they are adequately trained to safely handle horses in the starting gate. In emergency situations, the starter may appoint qualified individuals to act as substitute assistant starters;
- (3) Assign the starting gate stall positions to assistant starters and notify the assistant starters of their respective stall positions on race day before post time for each race;

(4) Assess the ability of each person applying for a jockey's license in breaking from the starting gate and working a horse in the company of other horses, and make said assessment known to the stewards; and

(5) Load horses into the gate in any order deemed necessary to ensure a safe and fair start.

*b. Assistant starters.* With respect to an official race, the assistant starters shall not:

(1) Handle or take charge of any horse in the starting gate without the expressed permission of the starter;

(2) Impede the start of a race;

(3) Use excessive force, a whip or other device, with the exception of steward-approved tongs, to assist in loading a horse into the starting gate;

(4) Slap, boot, or otherwise dispatch a horse from the starting gate;

(5) Strike or use abusive language to a jockey; or

(6) Accept or solicit any gratuity or payment other than their regular salary, directly or indirectly, for services in starting a race.

*c. Starter's list.* No horse shall be permitted to start in a race unless approval is given by the starter. The starter shall maintain a starter's list of all horses which are ineligible to be entered in any race because of poor or inconsistent behavior or performance in the starting gate. Any horse on the starter's list shall be refused entry until the horse has demonstrated to the starter that it has been satisfactorily schooled in the gate and can be removed from the starter's list. Schooling shall be under the direct supervision of the starter.

**10.4(9) Timer/clocker.**

*a. General authority—timer.*

(1) The timer shall accurately record the official time.

(2) At the end of a race, the timer shall post the official running time on the infield totalizator board on instruction by the stewards.

(3) At a facility equipped with an appropriate infield totalizator board, the timer shall post the quarter times (splits) for thoroughbred races in fractions as a race is being run. For quarter horse races, the timer shall post the official times in hundredths of a second.

(4) For backup purposes, the timer shall also use a stopwatch to time all races. In time trials, the timer shall ensure that at least two stopwatches are used by the stewards or their representatives.

(5) The timer shall maintain, and make available for inspection by the stewards or the commission on request, a written record of fractional and finish times of each race.

*b. General authority—clocker.*

(1) The clocker shall be present during training hours at each track on facility premises which is open for training to identify each horse working out and to accurately record the distances and times of each horse's workout.

(2) Each day, the clocker shall prepare a list of workouts that includes the name of each horse which worked along with the distance and time of each horse's workout.

(3) At the conclusion of training hours, the clocker shall deliver a copy of the list of workouts to the stewards and the racing secretary.

**10.4(10) Placing judges.**

*a. General authority.* The placing judges shall determine the order of finish in a race as the horses pass the finish line and, with the approval of the stewards, may display the results on the totalizator board.

*b. Photo finish.*

(1) In the event the placing judges or the stewards request a photo of the finish, the photo finish sign shall be posted on the totalizator board.

(2) Following their review of the photo finish film strip, the placing judges shall, with the approval of the stewards, determine the exact order of finish for all horses participating in the race, and shall immediately post the numbers of the first four finishers on the totalizator board.

(3) In the event a photo was requested, the placing judges shall cause a photographic print of said finish to be produced. The finish photograph shall, when needed, be used by the placing judges as an aid in determining the correct order of finish.

(4) Upon determination of the correct order of finish of a race in which the placing judges have utilized a photographic print to determine the first four finishers, the placing judges shall cause prints of said photograph to be displayed publicly in the grandstand and clubhouse areas of the facility.

*c. Dead heats.*

(1) In the event the placing judges determine that two or more horses finished the race simultaneously and cannot be separated as to their order of finish, a dead heat shall, with the approval of the stewards, be declared.

(2) In the event one or more of the first four finishers of a race are involved in a dead heat, the placing judges shall post the dead heat sign on the totalizator board and cause the numbers of the horse or horses involved to blink on the totalizator board.

**10.4(11) Jockey room custodian.** The jockey room custodian shall:

- a.* Supervise the conduct of the jockeys and their attendants while they are in the jockey room;
- b.* Keep the jockey room clean and safe for all jockeys;
- c.* Ensure all jockeys are in the correct colors and wearing the correct arm number before leaving the jockey room to prepare for mounting their horses;
- d.* Keep a daily film list as dictated by the stewards and have it displayed in plain view for all jockeys;
- e.* Keep a daily program displayed in plain view for the jockeys;
- f.* Keep unauthorized persons out of the jockey room;
- g.* Report to the stewards any unusual occurrences in the jockey room or infraction of the rules with respect to helmets and vests;
- h.* Assist the clerk of scales as required;
- i.* Supervise the care and storage of racing colors; and
- j.* Assign to each jockey a locker for the use of storing the jockey's clothing, equipment, and personal effects.

**10.4(12) Mutuel manager.** The mutuel manager is responsible for the operation of the mutuel department. The mutuel manager shall ensure that any delays in the running of official races caused by totalizator malfunctions are reported to the stewards. The mutuel manager shall submit a written report on any delay when requested by the state steward.

**10.4(13) Clerk of scales.** The clerk of scales shall:

- a.* Verify the presence of all jockeys in the jockey room at the appointed time;
- b.* Verify that each jockey has a current jockey's license issued by the commission;
- c.* Verify the correct weight of each jockey at the time of weighing out and weighing in and report any discrepancies to the stewards immediately;
- d.* Oversee the security of the jockey room including the conduct of the jockeys and their attendants;
- e.* Record all required data on the scale sheet and submit that data to the horsemen's bookkeeper at the end of each race day;
- f.* Maintain the record of applicable winning races on all apprentice certificates at the meeting;
- g.* Release apprentice jockey certificates, upon the jockey's departure or upon the conclusion of the race meet;
- h.* Assume the duties of the jockey room custodian in the absence of such employee; and
- i.* Promptly report to the stewards any infraction of the rules with respect to riding equipment; safety equipment, including, but not limited to, helmets and vests; riding crops; or conduct.

**10.4(14) Outrider.**

*a.* The facility shall appoint a minimum of two outriders on the main track for each race of a performance and during workouts. The facility shall appoint one outrider on the training track during all workouts. The outriders must be neat in appearance, wear approved helmets with the chin straps securely fastened, and wear approved safety vests while on the main track or training track.

*b.* The outriders shall:

- (1) Accompany the field of horses from the paddock to the post;

(2) Ensure the post parade is conducted in an orderly manner, with all jockeys and pony riders conducting themselves in a manner in conformity with the best interests of racing as determined by the board of stewards;

(3) Assist jockeys with unruly horses;

(4) Render assistance when requested by a jockey;

(5) Be present during morning workouts to assist exercise riders as required by regulations;

(6) Promptly report to the stewards any unusual conduct which occurs while performing the duties of an outrider;

(7) Ensure individuals using the track(s) are appropriately licensed; and

(8) Promptly report jockey objections to the stewards after the finish of each race.

**10.4(15) *Horsemen's bookkeeper.***

*a.* General authority. The horsemen's bookkeeper shall maintain the records and accounts and perform the duties described herein and maintain such other records and accounts and perform such other duties as the facility and commission may prescribe.

*b.* Records.

(1) The records shall include the name, mailing address, social security number or federal tax identification number, and the state or country of residence of each horse owner, trainer, or jockey participating at the race meeting who has funds due or on deposit in the horsemen's account.

(2) The records shall include a file of all required statements of partnerships, syndicates, corporations, assignments of interest, lease agreements, and registrations of authorized agents.

(3) All records of the horsemen's bookkeeper shall be kept separate and apart from the records of the facility.

(4) All records of the horsemen's bookkeeper including records of accounts and moneys and funds kept on deposit are subject to inspection by the commission at any time.

*c.* Moneys and funds on account.

(1) All moneys and funds on account with the horsemen's bookkeeper shall be maintained:

1. Separate and apart from moneys and funds of the facility;

2. In a trust account designated as "horsemen's trust account"; and

3. In an account insured by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation.

(2) The horsemen's bookkeeper shall be bonded.

*d.* Payment of purses.

(1) The horsemen's bookkeeper shall receive, maintain, and disburse the purses of each race and all stakes, entrance money, jockey fees, purchase money in claiming races, all applicable taxes, and other moneys that properly come into the horsemen's bookkeeper's possession in accordance with the provisions of commission rules.

(2) The horsemen's bookkeeper may accept moneys due, belonging to other organizations or recognized meetings, provided prompt return is made to the organization to which the money is due.

(3) The horsemen's bookkeeper shall disburse the purse of each race and all stakes, entrance money, and jockey fees, upon request, within two race days of the conclusion of the race day for all horses that were not selected for postrace drug testing.

(4) For horses that were selected for postrace drug testing, the horsemen's bookkeeper shall disburse the purse of such horses for each race and all stakes, entrance money, and jockey fees, upon request, within two race days of receipt of notification that all tests with respect to such horses have cleared the drug testing laboratory (commission chemist) as reported by the stewards. Minimum jockey mount fees may be disbursed prior to notification that the tests have cleared the testing laboratory.

(5) Absent a prior request, the horsemen's bookkeeper shall disburse moneys to the persons entitled to receive same within 15 days after the last race day of the race meeting, including purses for official races, provided that all tests with respect to such horses that have been selected for postrace drug testing have cleared the drug testing laboratory as reported by the stewards, and provided further that no protest or appeal has been filed with the stewards or the commission.

(6) In the event a protest or appeal has been filed with the stewards or the commission, the horsemen's bookkeeper shall disburse the purse of such horses having been selected for posttrace drug testing within two race days of receipt of dismissal or a final nonappealable order disposing of such protest or appeal.

*e.* No portion of purse money other than jockey fees shall be deducted by the facility for itself or for another, unless so requested in writing by the person to whom purse moneys are payable or the person's duly authorized representative. The horsemen's bookkeeper shall mail to each owner a duplicate of each record of all deposits, withdrawals, or transfers of funds affecting the owner's racing account at the close of each race meeting.

*f.* Purse money presumption. The fact that purse money has been distributed prior to the issuance of a laboratory report shall not be deemed a finding that no chemical substance has been administered, in violation of these rules, to the horse earning the purse money.

**10.4(16) Patrol judges.**

*a.* *General authority.* A facility may employ patrol judges who shall observe the running of the race and report information concerning the running of the race to the stewards.

*b.* *Duty stations.* Each patrol judge shall have a duty station assigned by the stewards.

**10.4(17) Commission veterinarians.**

*a.* The veterinarians shall advise the commission and the stewards on all veterinary matters.

*b.* The commission veterinarians shall have supervision and control of the detention barn for the collection of test samples for the testing of horses for prohibited medication as provided in Iowa Code sections 99D.23(2) and 99D.25(9). The commission may employ persons to assist the commission veterinarians in maintaining the detention barn area and collecting test samples.

*c.* The commission veterinarians shall not buy or sell any horse under their supervision; wager on a race under their supervision; or be licensed to participate in racing in any other capacity.

*d.* The stewards or commission veterinarians may request any horse entered in a race to undergo an examination on the day of the race to determine the general fitness of the horse for racing. During the examination, all bandages shall be removed by the groom upon request and the horse may be exercised outside the stall to permit the examiner to determine the condition of the horse's legs and feet. The examining veterinarian shall report any unsoundness in a horse to the stewards.

*e.* A commission veterinarian shall inspect all of the horses in a race at the starting gate and after the finish of a race shall observe the horses upon their leaving the track.

*f.* The commission veterinarian shall place any horse determined to be sick or too unsafe, unsound, or unfit to race on a veterinarian's list that shall be posted in a conspicuous place available to all owners, trainers, and officials.

*g.* A horse placed on the veterinarian's list in Iowa, bleeders exempt, may be allowed to enter only after it has been approved by the commission veterinarian. Any horse placed on the veterinarian's list will be removed from any future race in which the horse has been entered. Requests for the removal of any horse from the veterinarian's list will be accepted only after a minimum of three calendar days have elapsed from the placing of the horse on the veterinarian's list. Removal from the list will be at the discretion of the commission veterinarian, who may require satisfactory workouts or examinations to adequately demonstrate that the problem that caused the horse to be placed on the list has been rectified. Horses that are entered to race and then placed on the veterinarian's list for any reason will not be allowed to enter a race for a minimum of three calendar days beginning the day after the horse was scheduled to race.

Every confirmed bleeder, regardless of age, shall be placed on the bleeder list and be ineligible to race for the following time periods:

- (1) First incident – 14 days.
- (2) Second incident within 365-day period – 30 days.
- (3) Third incident within 365-day period – 180 days.
- (4) Fourth incident within 365-day period – barred for racing lifetime.

For the purposes of counting the number of days a horse is ineligible to run, the day the horse bled externally is the first day of the recovery period. The voluntary administration of furosemide without

an external bleeding incident shall not subject the horse to the initial period of ineligibility specified in subparagraph (1). A horse may be removed from the bleeder list only upon the direction of the official veterinarian, who shall certify in writing to the stewards the recommendation for removal. A horse which has been placed on a bleeder list in another jurisdiction pursuant to these rules shall be placed on a bleeder list in this jurisdiction.

*h.* The commission veterinarians shall supervise and ensure that the administration of furosemide and phenylbutazone is in compliance with Iowa Code section 99D.25A.

*i.* Rescinded IAB 9/29/04, effective 11/3/04.

*j.* The commission veterinarian or commission representative shall take receipt of veterinary reports as required by Iowa Code section 99D.25(10).

[ARC 0734C, IAB 5/15/13, effective 6/19/13; see Delay note at end of chapter; ARC 1876C, IAB 2/18/15, effective 3/25/15; ARC 2468C, IAB 3/30/16, effective 5/4/16; ARC 2927C, IAB 2/1/17, effective 3/8/17; ARC 3608C, IAB 1/31/18, effective 3/7/18; ARC 4194C, IAB 12/19/18, effective 1/23/19; ARC 4378C, IAB 3/27/19, effective 5/1/19; ARC 4954C, IAB 2/26/20, effective 4/1/20; ARC 5423C, IAB 2/10/21, effective 3/17/21]

#### **491—10.5(99D) Trainer, jockey, and jockey agent responsibilities.**

##### **10.5(1) Trainer.**

*a. Responsibility.* The trainer is responsible for:

(1) The condition of horses entered in an official workout or race and, in the absence of substantial evidence to the contrary, for the presence of any prohibited drug, medication or other substance, including permitted medication in excess of the maximum allowable level, in such horses, regardless of the acts of third parties. A positive test for a prohibited drug, medication, or substance, including permitted medication in excess of the maximum allowable level, as reported by a commission-approved laboratory, is prima facie evidence of a violation of this rule or Iowa Code chapter 99D.

(2) Preventing the administration of any drug, medication, or other prohibited substance that may cause a violation of these rules. An “in-today” sign must be placed by 8 a.m. on race day next to the stall of a horse that is scheduled to race on that day. For horses shipping in on race day, the sign must be placed upon the horse’s arrival.

(3) Any violation of rules regarding a claimed horse’s participation in the race in which the trainer’s horse is claimed.

(4) The condition and contents of stalls, tack rooms, feed rooms, sleeping rooms, and other areas which have been assigned to the trainer by the facility and maintaining the assigned stable area in a clean, neat, and sanitary condition at all times.

(5) Ensuring that fire prevention rules are strictly observed in the assigned stable area.

(6) Being present to witness the administration of furosemide during the administration time and sign as the witness on the affidavit form. A licensed designee of the trainer may witness the administration of the furosemide and sign as the witness on the affidavit form; however, this designee may not be another practicing veterinarian or veterinary assistant. If the trainer or designee is not present or does not allow for the administration of furosemide to a horse to be run on furosemide, said horse will be placed on the steward’s list for a minimum of five days starting the day after the violation.

(7) The proper identity, custody, care, health, condition, and safety of horses in the trainer’s charge.

(8) Disclosure to the racing secretary of the true and entire ownership of each horse in the trainer’s care, custody, or control. Any change in ownership shall be reported immediately to, and approved by, the stewards and recorded by the racing secretary. The disclosure, together with all written agreements and affidavits setting out oral agreements pertaining to the ownership for or rights in and to a horse, shall be attached to the registration certificate for the horse and filed with the racing secretary.

(9) Training all horses owned wholly or in part by the trainer which are participating at the race meeting.

(10) Registering with the racing secretary each horse in the trainer’s charge within 24 hours of the horse’s arrival on facility premises.

(11) Ensuring that, at the time of arrival at the facility, each horse in the trainer’s care is accompanied by a valid health certificate which shall be filed with the racing secretary.

(12) Having each horse in the trainer's care that is racing or stabled on facility premises tested for equine infectious anemia (EIA) in accordance with state law and for filing evidence of such negative test results with the racing secretary. The test must have been conducted within the previous 12 months and must be repeated upon expiration. The certificate must be attached to the foal certificate or otherwise accessible by the commission or racing association.

(13) Using the services of those veterinarians licensed by the commission to attend horses that are on facility premises.

(14) Properly recording the sex of the horses in the trainer's care with the horse identifier and the racing secretary and immediately reporting the alteration of the sex of a horse in the trainer's care to the horse identifier and the racing secretary.

(15) Promptly reporting to the racing secretary and the commission veterinarian any horse on which a posterior digital neurectomy (heel nerving) has been performed and ensuring that such fact is designated on its certificate of registration. See Iowa Code subsections 99D.25(1) to 99D.25(3).

(16) Promptly reporting to the stewards and the commission veterinarian the serious illness of any horse in the trainer's charge.

(17) Promptly reporting the death of any horse in the trainer's care on facility premises to the stewards, owner, and the commission veterinarian and complying with Iowa Code subsection 99D.25(5) governing postmortem examination.

(18) Maintaining a knowledge of the medication record and status of all horses in the trainer's care.

(19) Immediately reporting to the stewards and the commission veterinarian if the trainer knows, or has cause to believe, that a horse in the trainer's custody, care, or control has received any prohibited drugs or medication.

(20) Representing an owner in making entries and scratches and in all other matters pertaining to racing.

(21) Eligibility of horses entered and weight or other allowance claimed.

(22) Ensuring the fitness of a horse to perform creditably at the distance entered.

(23) Ensuring that the trainer's horses are properly shod, bandaged, and equipped.

(24) Presenting the trainer's horse in the paddock at least 20 minutes before post time or at a time otherwise appointed before the race in which the horse is entered. Any horse failing to report to the paddock will be placed on the steward's list for a minimum of five days starting the day after the violation.

(25) Personally attending to the trainer's horses in the paddock and supervising the saddling thereof, unless excused by the stewards.

(26) Instructing the jockey to give the jockey's best effort during a race and instructing the jockey that each horse shall be ridden to win.

(27) Witnessing the collection of a urine, blood, or hair sample from the horse in the trainer's charge or delegating a licensed employee or the owner of the horse to do so.

(28) Notifying horse owners upon the revocation or suspension of their trainer's license. A trainer whose license has been suspended for more than 30 days, whose license has expired or been revoked, or whose license application has been denied must inform the horse owners that, until the license is restored, the trainer can no longer be involved with the training, care, custody or control of their horses, nor receive any compensation from the owners for the training, care, custody or control of their horses. Upon application by the horse owner, the stewards may approve the transfer of such horse(s) to the care of another licensed trainer, and upon such approved transfer, such horse(s) may be entered to race. Upon transfer of such horse(s), the inactive trainer shall not be involved in any arrangements related to the care, custody or control of the horse(s) and shall not benefit financially or in any other way from the training of the horse(s).

(29) Ensuring that all individuals in their employ are properly licensed by the commission.

*b. Restrictions on wagering.* A trainer with a horse(s) entered in a race shall be allowed to wager only on that horse(s) or that horse(s) in combination with other horses.

*c. Assistant trainers.*

(1) Upon the demonstration of a valid need, a trainer may employ an assistant trainer as approved by the stewards. The assistant trainer shall be licensed prior to acting in such capacity on behalf of the trainer.

(2) Qualifications for obtaining an assistant trainer's license shall be prescribed by the stewards and the commission and may include requirements set forth in 491—Chapter 6.

(3) An assistant trainer may substitute for and shall assume the same duties, responsibilities and restrictions as are imposed on the licensed trainer, in which case the trainer shall be jointly responsible for the assistant trainer's compliance with the rules.

*d. Substitute trainers.*

(1) A trainer absent for more than five days from responsibility as a licensed trainer, or on a day in which the trainer has a horse in a race, shall obtain another licensed trainer to substitute.

(2) A substitute trainer shall accept responsibility for the horses in writing and shall be approved by the stewards.

(3) A substitute trainer and the absent trainer shall be jointly responsible as absolute insurers of the condition of their horses entered in an official workout or race.

**10.5(2) Jockey.**

*a. Responsibility.*

(1) A jockey shall give a best effort during a race, and each horse shall be ridden to win.

(2) A jockey shall not have a valet attendant except one provided and compensated by the facility.

(3) No person other than the licensed contract employer or a licensed jockey agent may make riding engagements for a rider, except that a jockey not represented by a jockey agent may make the jockey's own riding engagements.

(4) A jockey shall have no more than one jockey agent.

(5) No revocation of a jockey agent's authority is effective until the jockey notifies the stewards in writing of the revocation of the jockey agent's authority.

(6) A jockey shall promptly report objections to the outrider(s) following the finish of the race.

*b. Jockey betting.* A jockey shall be allowed to wager only on a race in which the jockey is riding. A jockey shall be allowed to wager only if:

(1) The owner or trainer of the horse that the jockey is riding makes the wager for the jockey;

(2) The jockey only wagers on the jockey's own mount to win or finish first in combination with other horses in multiple-type wagers; and

(3) Records of such wagers are kept and available for presentation upon request by the stewards.

*c. Jockey's spouse.* A jockey shall not compete in any race against a horse that is trained or owned by the jockey's spouse.

*d. Jockey mount fees.* Rescinded IAB 5/6/09, effective 6/10/09.

*e. Entitlement.* Any apprentice or contract rider shall be entitled to the regular jockey fees, except when riding a horse owned in part or solely by the contract holder. An interest in the winnings only (such as trainer's percent) shall not constitute ownership.

*f. Fee earned.* A jockey's fee shall be considered earned when the jockey is weighed out by the clerk of scales. The fee shall not be considered earned when injury to the horse or rider is not involved and jockeys, of their own free will, take themselves off their mounts. Any conditions or considerations not covered by the above shall be at the discretion of the stewards.

*g. Multiple engagements.* If any owner or trainer engages two or more jockeys for the same race, the owner or trainer shall be required to pay each of the jockeys the appropriate fee whether the jockeys ride in the race or not.

*h. Dead heats.* Jockeys finishing a race in a dead heat shall divide equally the totals they individually would have received had one jockey won the race alone. The owners of the horses finishing in the dead heat shall pay equal shares of the jockey fees.

*i. Apprentices subject to jockey rules.* Unless excepted under these rules, apprentices are subject to all rules governing jockeys and racing.

*j. Conduct.*

(1) Clothing and appearance. A jockey shall wear the racing colors furnished by the owner of the horse the jockey is to ride, plus solid white riding pants, top boots, and a number on the right shoulder on the saddlecloth corresponding to the mount's number given as shown on the saddlecloth and in the daily program. The stewards, at their discretion, may allow a jockey to wear solid black riding pants during poor weather or track conditions. The Jockeys' Guild logo, the Permanently Disabled Jockeys Fund logo, or the jockey's name may be displayed on the pants. The size of the display of the jockey's name on the pants is limited to a maximum of 32 square inches on each thigh of the pants on the outer sides between the hip and the knee, and 10 square inches on the rear at the base of the spine. A jockey shall not wear advertising or promotional material of any kind on clothing during a race, unless the following criteria are met:

1. A maximum of 32 square inches on each thigh of the pants on the outer side between the hip and knee and 10 square inches on the rear of the pant at the waistline at the base of the spine.
2. A maximum of 24 square inches on boots and leggings on the outside of each nearest the top of the boot.
3. A maximum of 6 square inches on the front center of the neck area (on a turtleneck or other undergarment).
4. Such advertising or promotional material does not compete with, conflict with, or infringe upon any current sponsorship agreement to the racing association race or race meet.
5. The stewards, at their discretion, may disallow any advertising that is not in compliance with this rule, any other rules of racing, or any advertising the stewards deem to be inappropriate, indecent, in poor taste, or controversial.

(2) Competing against contractor. No jockey may ride in any race against a starting horse belonging to the jockey's contract employer unless the jockey's mount and the contract employer's horse are both trained by the same trainer.

(3) Confined to jockey room. Jockeys engaged to ride a race shall report to the jockey room on the day of the race at the time designated by the facility officials. The jockeys shall then report their engagements and any overweight to the clerk of scales. Thereafter, they shall not leave the jockey room, except by permission of the stewards, until all of their riding engagements of the day have been fulfilled. Once jockeys have fulfilled their riding engagements for the day and have left the jockeys' quarters, they shall not be readmitted to the jockeys' quarters until after the entire racing program for that day has been completed, except upon permission of the stewards. Jockeys are not allowed to communicate with anyone but the trainer while in the room during the performance except with approval of the stewards. On these occasions, they shall be accompanied by a security guard.

(4) Whip prohibited. Jockeys may not use a whip on a two-year-old horse before April 1 of each year, nor shall a jockey or other person engage in excessive or indiscriminate whipping of any horse at any time.

(5) Spurs prohibited. Jockeys shall not use spurs.

(6) Possessing drugs or devices. Jockeys shall not have in their care, control, or custody any drugs, prohibited substances, or electrical or mechanical device that could affect a horse's racing performance.

*k. Jockey effort.* A jockey shall exert every effort to ride the horse to the finish in the best and fastest run of which the horse is capable. No jockey shall ease up or coast to a finish, without adequate cause, even if the horse has no apparent chance to win prize money.

*l. Duty to fulfill engagements.* Jockeys shall fulfill their duly scheduled riding engagements, unless excused by the stewards. Jockeys shall not be forced to ride a horse they believe to be unsound or over a racing strip they believe to be unsafe. If the stewards find a jockey's refusal to fulfill a riding engagement is based on personal belief unwarranted by the facts and circumstances, the jockey may be subject to disciplinary action. Jockeys shall be responsible to their agent for any engagements previously secured by the agent.

*m. Riding interference.*

(1) When the way is clear in a race, a horse may be ridden to any part of the course; but if any horse swerves, or is ridden to either side, so as to interfere with, impede, or intimidate any other horse, it is a foul.

(2) The offending horse may be disqualified if, in the opinion of the stewards, the foul altered the finish of the race, regardless of whether the foul was accidental, willful, or the result of careless riding. When a horse causes interference under this rule, every horse in the same race entered by the same owner or trainer who benefited from the interference may be disqualified at the discretion of the stewards.

(3) If the stewards determine the foul was intentional, or due to careless riding, the jockey shall be held responsible.

(4) In a straightaway race, every horse must maintain position as nearly as possible in the lane in which it started. If a horse is ridden, drifts, or swerves out of its lane in such a manner that it interferes with, impedes, or intimidates another horse, it is a foul and may result in the disqualification of the offending horse.

*n. Jostling.* Jockeys shall not jostle another horse or jockey. Jockeys shall not strike another horse or jockey or ride so carelessly as to cause injury or possible injury to another horse in the race.

*o. Partial fault/third-party interference.* If a horse or jockey interferes with or jostles another horse, the aggressor may be disqualified, unless the interfered or jostled horse or jockey was partly at fault or the infraction was wholly caused by the fault of some other horse or jockey.

*p. Careless riding.* A jockey shall not ride carelessly or willfully permit the mount to interfere with, intimidate, or impede any other horse in the race. A jockey shall not strike at another horse or jockey so as to impede, interfere with, or injure the other horse or jockey. If a jockey rides in a manner contrary to this rule, the horse may be disqualified; or the jockey may be fined, suspended, or otherwise disciplined; or other penalties may apply.

*q. Jockey weighed out.*

(1) Jockeys must be weighed for their assigned horse not more than 30 minutes before the time fixed for the race.

(2) A jockey's weight shall include the jockey's clothing, boots, saddle and its attachments. A safety vest shall be mandatory, shall weigh no more than two pounds, and shall be designed to provide shock-absorbing protection to the upper body.

(3) All other equipment shall be excluded from the weight.

*r. Overweight limited.* No jockey may weigh more than two pounds or, in the case of inclement weather, four pounds over the weight the horse is assigned to carry unless with consent of the owner or trainer and unless the jockey has declared the amount of overweight to the clerk of scales at least 60 minutes before the scheduled post time of the first race. However, a horse shall not carry more than seven pounds overweight, except in inclement weather when nine pounds shall be allowed. The overweight shall be publicly announced and posted in a conspicuous place both prior to the first race of the day and before the running of the race.

(1) Weigh in. Upon completion of a race, jockeys shall ride promptly to the winner's circle and dismount. Jockeys riding the first four finishers, or at the discretion of the stewards a greater number, shall present themselves to the clerk of scales to be weighed in. If a jockey is prevented from riding the mount to the winner's circle because of accident or illness either to the jockey or the horse, the jockey may walk or be carried to the scales unless excused by the stewards.

(2) Unsaddling. Jockeys, upon completion of a race, must return to the unsaddling area and unsaddle their own horse, unless excused by the stewards.

(3) Removing horse's equipment. No person except the valet attendant for each mount is permitted to assist the jockey in removing the horse's equipment that is included in the jockey's weight, unless the stewards permit otherwise. To weigh in, jockeys shall carry to the scales all pieces of equipment with which they weighed out. Thereafter they may hand the equipment to the valet attendant.

(4) Underweight. When any horse places first, second, or third in a race and thereafter the horse's jockey is weighed in short by more than two pounds of the weight of which the jockey was weighed out, the mount may be disqualified and all purse moneys forfeited.

(5) Overweight. If the jockey is overweight, the jockey is subject to fine, suspension, or both.

*s. Contracts.* Rescinded IAB 5/16/01, effective 6/20/01.

*t. Jockey fines and forfeitures.* Jockeys shall pay any fine or forfeiture from their own funds within 48 hours of the imposition of the fine or at a time deemed proper by the stewards. No other person shall pay jockey fines or forfeitures for the jockey.

*u. Competing claims.* Whenever two or more licensees claim the services of one jockey for a race, first call shall have priority and any dispute shall be resolved by the stewards.

*v. Jockey suspension.*

(1) Offenses involving fraud. Suspension of a licensee for an offense involving fraud or deception in racing shall begin immediately after the ruling unless otherwise ordered by the stewards or commission.

(2) Offenses not involving fraud. Suspension for an offense not involving fraud or deception in racing shall begin on the third day after the ruling or at the stewards' discretion.

(3) Withdrawal of appeal. Withdrawal by the appellant of a notice of appeal filed with the commission, whenever imposition of the disciplinary action has been stayed or enjoined pending a final decision by the commission, shall be deemed a frivolous appeal and referred to the commission for further disciplinary action in the event the appellant fails to show good cause to the stewards why the withdrawal should not be deemed frivolous.

(4) Riding suspensions of ten days or less and participating in designated races. The stewards appointed for a race meeting shall immediately, prior to the commencement of that meeting, designate the stakes, futurities, futurity trials, or other races in which a jockey will be permitted to compete, notwithstanding the fact that such jockey is under suspension for ten days or less for a careless riding infraction at the time the designated race is to be run.

1. Official rulings for riding suspensions of ten days or less shall state: "The term of this suspension shall not prohibit participation in designated races."

2. A listing of the designated races shall be posted in the jockey room and any other such location deemed appropriate by the stewards.

3. A suspended jockey must be named at time of entry to participate in any designated race.

4. A day in which a jockey participated in one designated race while on suspension shall count as a suspension day. If a jockey rides in more than one designated race on a race card while on suspension, the day shall not count as a suspension day. Each designated trial race for a stake shall be considered one race. A jockey who rides in more than one designated race shall be allowed to be named to ride other races on a card, and such race card shall not count as a suspended race day.

**10.5(3) Apprentice jockey.** Upon completion of licensing requirements, the stewards may issue an apprentice jockey certificate allowing the holder to claim this allowance only in overnight races.

*a.* An apprentice jockey shall ride with a five-pound weight allowance beginning with the first mount and for one full year from the date of the jockey's fifth winning mount.

*b.* If, after riding one full year from the date of the fifth winning mount, the apprentice jockey has not ridden 40 winners, the applicable weight allowance shall continue for one more year or until the fortieth winner, whichever comes first. In no event shall a weight allowance be claimed for more than two years from the date of the fifth winning mount, unless an extension has been granted.

*c.* The steward may extend the weight allowance of an apprentice jockey when, in the discretion of the steward, the apprentice provides proof of incapacitation for a period of seven or more consecutive days. The allowance may be claimed for a period not to exceed the period such apprentice was unable to ride.

*d.* The apprentice jockey must have the apprentice certificate with the jockey at all times and must keep an updated record of the first 40 winners. Prior to riding, the jockey must submit the certificate to the clerk of scales, who will record the apprentice's winning mounts.

**10.5(4) Jockey agent.**

*a.* Responsibilities.

(1) A jockey agent shall not make or assist in making engagements for a jockey other than the jockeys the agent is licensed to represent.

(2) A jockey agent shall file written proof of all agencies and changes of agencies with the stewards.

(3) A jockey agent shall notify the stewards, in writing, prior to withdrawing from representation of a jockey and shall submit to the stewards a list of any unfulfilled engagements made for the jockey.

(4) All persons permitted to make riding engagements shall maintain current and accurate records of all engagements made. Such records shall be subject to examination by the stewards at any time.

(5) No jockey agent shall represent more than two jockeys and one apprentice jockey at the same time except:

1. A jockey agent may represent three jockeys at a “mixed” meeting so long as no more than two of the jockeys ride the same breed. In addition, a jockey agent may represent one apprentice jockey who may ride either breed.

2. A jockey agent may represent three jockeys at a race meeting exclusive of thoroughbred racing.

(6) A jockey agent must honor a first call given to a trainer or the trainer’s assistant trainer.

b. Prohibited areas. A jockey agent is prohibited from entering the jockey room, winner’s circle, racing strip, paddock, or saddling enclosure during the hours of racing.

c. A jockey agent shall not be permitted to withdraw from the representation of any jockey unless written notice to the stewards has been provided.

[ARC 7757B, IAB 5/6/09, effective 6/10/09; ARC 0734C, IAB 5/15/13, effective 6/19/13; ARC 1456C, IAB 5/14/14, effective 6/18/14; ARC 1876C, IAB 2/18/15, effective 3/25/15; ARC 2468C, IAB 3/30/16, effective 5/4/16; ARC 2927C, IAB 2/1/17, effective 3/8/17; ARC 3608C, IAB 1/31/18, effective 3/7/18; ARC 4194C, IAB 12/19/18, effective 1/23/19; ARC 4378C, IAB 3/27/19, effective 5/1/19; ARC 4954C, IAB 2/26/20, effective 4/1/20; ARC 5423C, IAB 2/10/21, effective 3/17/21]

#### **491—10.6(99D) Conduct of races.**

**10.6(1)** Horses ineligible. Any horse ineligible to be entered for a race, or ineligible to start in any race, which competes in that race may be disqualified and the stewards may discipline the persons responsible for the horse competing in that race.

a. A horse is ineligible to enter a race when:

(1) The nominator has failed to identify the horse which is being entered for the first time, by name, color, sex, age, and the names of sire and dam as registered.

(2) A horse has been knowingly entered or raced in any jurisdiction under a different name, with an altered registration certificate, altered microchip, or altered lip or digital tattoo by a person having lawful custody or control of the horse for the purpose of deceiving any facility or regulatory agency.

(3) A horse has been allowed to enter or start by a person having lawful custody or control of the horse who participated in or assisted in the entry or racing of some other horse under the name of the horse in question.

(4) A horse is wholly or partially owned by a disqualified person or a horse is under the direct or indirect management of a disqualified person.

(5) A horse is wholly or partially owned by the spouse of a disqualified person or a horse is under the direct or indirect management of the spouse of a disqualified person. In such cases, a presumption which may be rebutted is that the disqualified person and spouse constitute a single financial entity with respect to the horse.

(6) A horse is owned in whole or in part by an undisclosed person or interest.

(7) A horse has been nerved by surgical neurectomy.

(8) A horse has been trachea-tubed to artificially assist breathing.

(9) A horse has impaired eyesight in both eyes.

(10) A horse appears on the Iowa veterinarian’s list, notwithstanding a horse appearing on the veterinarian’s list as a “bleeder.” In addition, a horse appearing on any starter’s, stewards’, or paddock judge’s list, or the veterinarian’s list in another jurisdiction, is ineligible unless the horse is removed from the list by the day of the race and approved by the board of stewards to enter.

(11) A horse is barred from racing in any racing jurisdiction.

(12) A horse under four years of age has been injected with bisphosphonates. A horse four years of age or older may only be administered bisphosphonate if the bisphosphonate is Food and Drug Administration-approved for use in the horse and administered in accordance with the label requirements and only for diagnosed cases of navicular disease. If bisphosphonate is administered as permitted by rule, the commission shall be notified within 24 hours of the administration. If

bisphosphonate is detected in sampling or if a horse is administered bisphosphonate, the horse shall be placed on the veterinarian's list for no less than six months.

(13) A horse has had any intra-articular joint injection within the past six days. For the purpose of counting the number of days a horse is ineligible to run following an intra-articular injection, the day of injection is the first day. The detection of two or more corticosteroids constitutes a stacking violation.

(14) A horse has been administered thyroxine and thyroid modulators/hormones including, but not limited to, those containing T4 (tetraiodothyronine/thyroxine), T3 (triiodothyronine), or combinations thereof. This excludes a horse that has been individually prescribed thyroxine and thyroid modulators/hormones.

*b.* A horse is ineligible to start a race when:

(1) The horse is not stabled on the premises of the facility by the time designated by the stewards.

(2) The horse's breed registration certificate is not on file, physically or digitally, with the racing secretary, or horse identifier, except where the racing secretary has submitted the certificate to the breed registry for correction or transfer of ownership. The stewards may, in their discretion, waive the requirement provided the registration certificate is in the possession of another board of stewards, a copy of the registration certificate is on file with the racing secretary, and the horse is otherwise properly identified. For claiming races, if the claimed horse has been approved by the stewards to run without the registration certificate on file in the racing office, then the registration certificate must be provided to the racing office within seven business days for transfer to the new owner before claiming funds will be approved for transfer by the stewards.

(3) The horse is not fully identified by an official tattoo on the inside of the upper lip or digital tattoo or microchip.

(4) A horse is brought to the paddock and is not in the care of and saddled by a currently licensed trainer or assistant trainer unless excused by the stewards.

(5) No current negative Coggins test or current negative equine infectious anemia test certificate is attached to the horse's registration certificate or otherwise accessible by the commission or racing association.

(6) The stakes or entrance money for the horse has not been paid.

(7) The horse appears on the starter's list, stewards' list, paddock list, or veterinarian's list.

(8) The horse is a first-time starter not approved by the starter and does not have a minimum of two official workouts for quarter horses or a minimum of three official workouts for thoroughbreds.

(9) Within the past calendar year, the horse has started in a race that has not been reported in a nationally published monthly chartbook, unless, at least 48 hours prior to entry, the owner of the horse provides to the racing secretary performance records which show the place and date of the race, distance, weight carried, amount carried, and the horse's finishing position and time.

(10) In a stakes race, a horse has been transferred with its engagements, unless prior to the start, the fact of transfer of the horse and its engagements has been filed with the racing secretary.

(11) A horse is subject to a lien which has not been approved by the stewards and filed with the horsemen's bookkeeper.

(12) A horse is subject to a lease not filed with the stewards.

(13) A horse is not in sound racing condition.

(14) A horse has been blocked with alcohol or injected with any other foreign substance or drug to desensitize the nerves of the leg.

(15) A horse appears on the veterinarian's list as a "bleeder."

*c.* A horse is ineligible to start in a race when:

(1) A thoroughbred has shoes (racing plates) which have toe grabs with a height greater than two millimeters (0.07874 inches), bends, jars, caulks, stickers or any other traction device on the front hooves while racing or training on all racing surfaces.

(2) A quarter horse has front shoes which have toe grabs with a height greater than four millimeters (0.15748 inches), bends, jars, caulks, stickers or any other traction device worn on the front shoes.

**10.6(2)** Entries.

*a.* The facility shall provide forms for making entries and declarations with the racing secretary. Entries and declarations shall be in writing, or by telephone or fax subsequently confirmed in writing by the owner, trainer, or licensed designee. When any entrant or nominator claims failure or error in the receipt by a facility of any entry or declaration, the entrant or nominator may be required to submit evidence within a reasonable time of the filing of the entry or the declaration. Individuals who hold a jockey agent license, regardless of other licenses held, shall not be permitted to make entries after a time set by the stewards.

*b.* Upon the closing of entries the racing secretary shall promptly compile a list of entries and cause it to be conspicuously posted.

*c.* Coupling. There will be no coupled entries in any race. In races, excluding stakes races, that overflow, trainers must declare preference of runners with identical ownership at time of entry. Same-owner, second-choice horses will be least preferred. A trainer or owner may not enter more than three horses in a race unless the race is split or divided.

*d.* Split or divided races.

(1) In the event a race is canceled or declared off, the facility may split any overnight race for which post positions have not been drawn.

(2) Where an overnight race is split, forming two or more separate races, the racing secretary shall give notice of not less than 15 minutes before such races are closed to grant time for making additional entries to such split race.

(3) A trainer shall be allowed to enter more than the maximum number of entries allowed under paragraph 10.6(2)“c” if the entries are declared at time of entry as “split entry only” and preference is given by the trainer for the trainer’s first three entries.

(4) The racing secretary shall split an overnight race so that common ownership, identical ownership, or common trainer will divide as equally as possible between two or more races.

*e.* Entry weight. Owners, trainers, or any other duly authorized person who enters a horse for a race shall ensure that the entry is correct and accurate as to the weight allowances available and claimed for the horse under the conditions set for the race. After a horse is entered and has been assigned a weight to carry in the race, the assignment of weight shall not be changed except in the case of error and with the approval of the stewards. Weight allowances may be waived with the approval of the stewards.

*f.* Consecutive days. No horse shall be run twice within four consecutive calendar days. For the purpose of this rule, the day after the start shall count as the first day.

*g.* Foreign entries. For the purposes of determining eligibility, weight assignments, or allowances for horses imported from a foreign nation, the racing secretary shall take into account the “Pattern Race Book” published jointly by the Irish Turf Club, The Jockey Club of Great Britain, and the Société d’Encouragement.

*h.* Weight conversions. For the purpose of determining eligibility, weight assignments, or allowances for horses imported from a foreign nation, the racing secretary shall convert metric distances to English measures by reference to the following scale:

1 sixteenth	= 100 meters
1 furlong	= 200 meters
1 mile	= 1600 meters

*i.* Name. The “name” of a horse means the name reflected on the certificate of registration, racing permit, or temporary racing permit issued by the breed registry. Imported horses shall have a suffix, enclosed by brackets, added to their registered names showing the country of foaling. This suffix is derived from the international code of suffixes and constitutes part of the horse’s registered name. The registered names and suffixes, where applicable, shall be printed in the official program.

*j.* Bona fide entry. No person shall enter or attempt to enter a horse for a race unless that entry is a bona fide entry, made with the intention that the horse is to compete in the race for which the horse was entered.

*k.* Registration certificate to reflect correct ownership. Every breed registry foal certificate filed physically or digitally with the racing secretary to establish the eligibility of a horse to be entered for any race shall accurately reflect the correct and true ownership of the horse. The name of the owner that is printed on the official program for the horse shall conform to the ownership as declared on the certificate of registration or eligibility certificate unless a stable name has been registered with the commission for the owner or ownership.

*l.* Naming/engaging of riders. Riders must be named at the time of entry. If, at the conclusion of the draw of a race, a trainer does not have a rider, all riders who are available shall be made known to the trainer at that time via telephone or in person by the stewards or their designee. A trainer who does not name a rider prior to the conclusion of the draw of a race, and reasonable attempts have been employed to contact the trainer with no response, shall have an available rider engaged at the facility placed on the horse, determination of which shall be drawn by lot. Riders properly engaged as a first or second call in a race must fulfill their engagements as required in paragraph 10.5(2) "l."

*m.* More than one race. No horse may be entered in more than one race, with the exception of stakes races, to be run on the same day on which pari-mutuel wagering is conducted.

*n.* Iowa-foaled horse. An Iowa-foaled horse shall not be entered in a race limited to Iowa-foaled horses unless the horse is registered with and the papers are either physically or digitally stamped by the department of agriculture and land stewardship. An Iowa-foaled horse would be allowed to run in an open race without the stamp but would be ineligible for Iowa-bred supplement, Iowa-bred breeders awards and Iowa-bred breeders supplement.

#### **10.6(3) Sweepstakes entries.**

*a. Entry and withdrawal.* The entry of a horse in a sweepstakes is a subscription to the sweepstakes. Before the time of closing, any entry or subscription may be altered or withdrawn.

*b. Entrance money.* Entrance money shall be paid by the nominator to a race. In the event of the death of the horse or a mistake made in the entry of an otherwise eligible horse, the nominator subscriber shall continue to be obligated for any stakes, and the entrance money shall not be returned.

*c. Quarter horse scratches and qualifiers unable to participate in finals.* If a horse should be scratched from the time trial finals, the horse's owner will not be eligible for a refund of the fees paid. If a horse that qualified for the final should be unable to enter due to racing soundness, or scratched for any reason other than a positive drug test report or a rule violation, the horse shall be deemed to have earned and the owner will receive last place money. If more than one horse should be unable to enter due to racing soundness, or scratched for any reason other than a positive drug test report or a rule violation, then those purse moneys shall be added together and divided equally among the horse owners.

#### **10.6(4) Closing of entries.**

*a. Overnight entries.* Entries for overnight racing shall be closed at 10 a.m. by the racing secretary, unless a later closing is established by the racing secretary or unless approved by the stewards.

*b. Sweepstakes entries.* If an hour for closing is designated, entries and declarations for sweepstakes cannot be received thereafter. However, if a time for closing is not designated, entries and declarations may be mailed or faxed until midnight of the day of closing, if they are received in time to comply with all other conditions of the race. In the absence of notice to the contrary, entries and declarations for sweepstakes that close during or on the day preceding a race meeting shall close at the office of the racing secretary in accordance with any requirements the secretary shall make. Closing for sweepstakes not during race meetings shall be at the office of the facility.

*c. Exception.* Nominations for stakes races shall not close nor shall any eligibility payment be due on a day in which the United States Postal Service is not operating.

#### **10.6(5) Prohibited entries.**

*a. Entry by disqualified person.* An entry made by a disqualified person or the entry of a disqualified horse shall be void. Any money paid for the entry shall be returned, if the disqualification is disclosed at least 45 minutes before post time for the race. Otherwise, the entry money shall be paid to the winner.

*b. Limited partner entry prohibited.* No person other than a managing partner of a limited partnership or a person authorized by the managing partner may enter a horse owned by that partnership.

*c. Altering entries prohibited.* No alteration shall be made in any entry after the closing of entries, but the stewards may permit the correction of an error in an entry.

*d. Limitation on overnight entries.* If the number of entries to any purse or overnight race is in excess of the number of horses that may be accommodated due to the size of the track, the starters for the race and their post positions shall be determined by lot conducted in public by the racing secretary.

*e. Stake race entry limit.* In a stake race, the number of horses which may compete shall be limited only by the number of horses nominated and entered. In any case, the facility's lawful race conditions shall govern.

*f. Stewards' denial of entry.* The stewards may, after notice to the entrant, subscriber, or nominator, deny entry of any horse to a race if the stewards determine the entry to be in violation of these rules or the laws of this state or to be contrary to the interests of the commission in the regulation of pari-mutuel wagering or to public confidence in racing.

**10.6(6) Preferences and eligibles.**

*a. Also eligible.* A list of not more than eight names may be drawn from entries filed in excess of positions available in the race. These names shall be listed as "also eligible" to be used as entries if originally entered horses are withdrawn. Any owner, trainer, or authorized agent who has entered a horse listed as an "also eligible" and who does not wish to start shall file a scratch card with the secretary not later than the scratch time designated for that race. "Also eligibles" shall have preference to scratch.

*b. Preference system.* A system using dates or stars shall be used to determine preference for horses being entered in races. The system being used will be at the option of the racing secretary and approved by the stewards. A preference list will be kept current by the racing secretary and made available to horsemen upon request.

*c. Disputed decision.* When the decision of a race is in dispute, all horses involved in the dispute, with respect to the winner's credit or earnings, shall be liable to all weights or conditions attached to the winning of that race until a winner has been finally adjudged.

**10.6(7) Post positions.** Post positions shall be determined by the racing secretary publicly and by lot. Post positions shall be drawn from "also eligible" entries at scratch time. In all races, horses drawn into the race from the "also eligible" list shall take the outside post positions, except in straightaway quarter horse racing. In straightaway quarter horse racing, the post position of the scratched horse shall be assigned to the horse "drawing in." In the event there is more than one scratch, the post positions shall be assigned by lot.

**10.6(8) Scratch; declaring out.**

*a. Notification to the secretary.* No horse shall be considered scratched, declared out, or withdrawn from a race until the owner, agent, or other authorized person has given notice in writing to the racing secretary before the time set by the facility as scratch time. All scratches must be approved by the stewards.

*b. Declaration irrevocable.* Scratching or the declaration of a horse out of an engagement for a race is irrevocable.

*c. Limitation on scratches.* No horse shall be permitted to be scratched from a race if the horses remaining in the race number fewer than seven betting interests, unless the stewards permit a lesser number. When the number of requests to scratch would, if granted, leave a field of fewer than seven, the stewards shall determine by lot which entrants may be scratched and permitted to withdraw from the race. Veterinarian scratches will be preferred and accepted without regard to the number of entries.

*d. Scratch time.* Unless otherwise set by the stewards, scratch time shall be:

- (1) Stakes races. Scratch time shall be at least 45 minutes before post time.
- (2) Other races. Scratch time shall be set by the stewards prior to the start of the meet.

**10.6(9) Workouts.**

*a. Thoroughbreds, when required.*

(1) No horse shall be allowed to start unless the horse has raced in an official race or has had an approved official timed workout satisfactory to the stewards, and adheres to the following for horses that are not first-time starters:

1. A horse that has not started for a period of 60 days or more shall have had an official workout satisfactory to the stewards prior to the day of the race in which the horse started, and the horse must have had an official workout within the previous 30 days.

2. A horse that has not started for a period of 180 days or more shall have had two official workouts, one of which must have occurred within the previous 30 days prior to the day of the race in which the horse started.

3. A horse that has not started for a period of 365 days or more shall fulfill the following requirements before being allowed to start:

- The horse must have had three official workouts.
- One of the three official workouts must have been from the starting gate going at least one-half mile, within 60 days of starting.

(2) No first-time starter shall be allowed to race unless it has had three official workouts, with one having occurred from the gate within the previous 60 days and is approved to start from the gate by the starter.

*b. Quarter horses, when required.*

(1) No horse shall be allowed to start unless the horse has raced in an official race or has had an approved official timed workout satisfactory to the stewards, and adheres to the following for horses that are not first-time starters:

1. A horse that has not started for a period of 60 days or more shall be ineligible to race until it has had an official workout satisfactory to the stewards prior to the day of the race in which the horse started, and the horse must have had an official workout within the previous 60 days.

2. A horse that has not started for a period of 180 days or more shall have had two official workouts, one of which must have occurred within the previous 60 days.

3. A horse that has not started for a period of 365 days or more shall fulfill the following requirements before being allowed to start:

- The horse must have had two official workouts.
- One of the two official workouts must have been from the starting gate within 60 days of starting.

(2) No first-time starter shall be allowed to race unless it has had two official workouts, with one having occurred from the gate within the previous 60 days and is approved to start from the gate by the starter.

*c. Counting of days.* For the purpose of counting the number of days a horse is ineligible to start, the day after the workout shall be considered the first day.

*d. Identification.* The timer or the stewards may require licensees to identify a horse in their care being worked. The owner, trainer, or jockey may be required to identify the distance the horse is to be worked and the point on the track where the workout will start.

*e. Information dissemination.* If the stewards approve the timed workout so as to permit the horse to run in a race, they shall make it mandatory that this information be furnished to the public in advance of the race including, but not limited to, the following means:

- (1) Announcement over the facility's public address system;
- (2) Transmission on the facility's message board;
- (3) Posting in designated conspicuous places in the racing enclosure; and
- (4) Exhibit on track TV monitors at certain intervals if the track has closed circuit TV. If the workout is published prior to the race in either the Daily Racing Form or the track program, then it shall not be necessary to make the announcements set forth above.

*f. Restrictions.* No horse shall be taken onto the track for training or a workout except during hours designated by the facility.

#### **10.6(10) Equipment.**

*a. Whip and bridle limitations.* Unless permitted by the stewards, no whip or substitute for a whip shall exceed one pound or 30 inches and no bridle shall exceed two pounds.

*b. Equipment change.* No licensee may change the equipment used on a horse from that used in the horse's last race, unless with permission of the stewards. No licensee may add blinkers or cheek pieces to a horse's equipment or discontinue their use without the prior approval of the starter. First-time

starters must race with or without blinkers or cheek pieces in accordance with the gate approval card issued by the starter. In the paddock prior to a race, a horse's tongue may be tied down with clean bandages, clean gauze, or with a tongue strap.

**10.6(11) Racing numbers and silks.**

*a. Number display.* Each horse in a race shall carry a conspicuous saddle cloth number corresponding to the official number given that horse on the official program.

*b. Field horses.* In a combined field of horses, each horse in the field shall carry a separate number.

*c. Racing silks.* Racing silks shall be turned in to the racing office or jockey room custodian upon arrival to the facility.

(1) All horses running in a race are required to race in an owner's silk or trainer's silk.

(2) In the case of a partnership, the horse shall run with a managing partner's silk or a trainer's silk if no partnership silk is available.

(3) Under special circumstances, a horse may be permitted by the stewards to run in a house silk.

**10.6(12) Valuation of purse money.** Rescinded IAB 5/16/01, effective 6/20/01.

**10.6(13) Dead heats.**

*a.* When two horses run a dead heat for first place, all purses or prizes to which first and second horses would have been entitled shall be divided equally between them; and this applies in dividing all purses or prizes whatever the number of horses running a dead heat and whatever places for which the dead heat is run.

*b.* In the event of a dead-heat finish for second place and thereafter, when an objection to the winner of the race is sustained, the horses in the dead heat shall be considered to have run a dead heat for first place.

*c.* If a prize includes a cup, plate, or other indivisible prize, owners shall draw lots for the prize in the presence of at least two stewards.

**10.6(14) and 10.6(15) Rescinded IAB 3/27/19, effective 5/1/19.**

**10.6(16) Equine infectious anemia (EIA) test.**

*a. Certificate required.* No horse shall be allowed to start or be stabled on the premises of the facility unless a valid negative Coggins test or other laboratory-approved negative EIA test certificate is on file with the racing secretary.

*b. Trainer responsibility.* In the event of claims, sales, or transfers, it shall be the responsibility of the new trainer to ascertain the validity of the certificate for the horse within 24 hours. If the certificate is either unavailable or invalid, the previous trainer shall be responsible for any reasonable cost associated with obtaining a negative EIA laboratory certificate.

*c. Positive test reports.* Whenever any owner or trainer is furnished a positive Coggins test or positive EIA test result, the horse shall be removed by the owner or trainer from facility premises or approved farms within 24 hours of actual notice to the owner or trainer of the infection.

**10.6(17) Race procedures.**

*a. Full weight.* Each horse shall carry the full weight assigned for that race from the paddock to the starting point, and shall parade past the stewards' stand, unless excused by the stewards.

*b. Touching and dismounting prohibited.* After the horses enter the track, jockeys may not dismount or entrust their horse to the care of an attendant unless due to an accident occurring to the jockey, the horse, or the equipment, and then only with the prior consent of the starter. During any delay during which a jockey is permitted to dismount, all other jockeys may dismount and their horses may be attended by others. After the horses enter the track, only the hands of the jockey, the starter, the assistant starter, the commission veterinarian, an outrider on a lead pony, or persons approved by the stewards may touch the horse before the start of the race. If a horse throws its jockey on the way from the paddock to the post, the horse must be returned to the point where the jockey was thrown, where the horse shall be remounted and then proceed over the route of the parade to the post. The horse must carry its assigned weight from paddock to post and from post to finish.

*c. Jockey injury.* If a jockey is seriously injured on the way to the post, the horse shall be returned to the paddock, a replacement jockey obtained, and both the injured jockey and the replacement jockey will be paid by the owner.

*d. Twelve-minute parade limit.* After entering the track, all horses shall proceed to the starting post in not more than 12 minutes unless approved by the stewards. After passing the stewards' stand in parade, the horses may break formation and proceed to the post in any manner. Once at the post, the horses shall be started without unnecessary delay. All horses must participate in the parade carrying their weight and equipment from the paddock to the starting post, and any horse failing to do so may be disqualified by the stewards. No lead pony leading a horse in the parade shall obstruct the public's view of the horse being led except with permission of the stewards.

*e. Striking a horse prohibited.* In assisting the start of a race, no person other than the jockey, starter, assistant starter, or veterinarian shall strike a horse or use any other means to assist the start.

*f. Loading of horses.* Horses will be loaded into the starting gate in numerical order or in any other fair and consistent manner determined by the starter and approved by the stewards.

*g. Delays prohibited.* No person shall obstruct or delay the movement of a horse to the starting post.

**10.6(18) Claiming races.**

*a. Eligibility.*

(1) Registered to race or open claim. No person may file a claim for any horse unless the person:

1. Is a licensed owner at the meeting who either has foal paper(s) registered with the racing secretary's office or has started a horse at the meeting; or

2. Is a licensed authorized agent, authorized to claim for an owner eligible to claim; or

3. Has a valid open claim certificate. Any person not licensed as an owner, or a licensed authorized agent for the account of the same, or a licensed owner not having foal paper(s) registered with the racing secretary's office or who has not started a horse at the current meeting may request an open claim certificate from the commission. The person must submit a completed application for a prospective owner's license to the commission. The applicant must have the name of the trainer licensed by the commission who will be responsible for the claimed horse. A nonrefundable fee must accompany the application along with any financial information requested by the commission. The names of the prospective owners shall be prominently displayed in the offices of the commission and the racing secretary. The application will be processed by the commission; and when the open claim certificate is exercised, an owner's license will be issued; or

4. Is not a family member related within the second degree of affinity or consanguinity to the person or ownership entity who owns the horse. For the purpose of determining whether an ownership entity is excluded from claiming a horse or having a horse claimed, a family member within the second degree of affinity or consanguinity shall be defined as a parent, child, grandparent, grandchild, sibling, or in-law who owns or controls 5 percent or more of said entity.

(2) Number of claims.

1. An ownership entity (sole owner, partnership or limited liability partnership, racing stable, corporation or limited liability corporation, or owner/trainer acting as an owner) shall not claim more than one horse in a race, and an authorized agent or trainer acting on behalf of an ownership entity shall not submit more than two claims in a race with two separate ownership interests.

2. If an authorized agent or trainer acting on behalf of an ownership entity submits two claims in a race, the claims shall not be for the same horse.

3. A trainer shall not receive more than two horses from any claiming race.

*b. Procedure for claiming.* To make a claim for a horse, an eligible person shall:

(1) Deposit to the person's account with the horsemen's bookkeeper the full claiming price and applicable taxes as established by the racing secretary's conditions.

(2) File in a locked claim box maintained for that purpose by the stewards the claim filled out completely in writing and with sufficient accuracy to identify the claim on forms provided by the facility at least ten minutes before the time of the race.

*c. Claim box.*

(1) The claim box shall be approved by the commission and kept locked until ten minutes prior to the start of the race, when it shall be presented to the stewards or their representatives for opening and publication of the claims.

(2) The claim box shall also include a time clock which automatically stamps the time on the claim envelope prior to its being dropped in the box.

(3) No official of a facility shall give any information as to the filing of claims therein until after the race has been run.

*d. Claim irrevocable.* After a claim has been filed in the claim box, it shall not be withdrawn.

*e. Multiple claims on single horses.* If more than one claim is filed on a horse, the successful claim shall be determined by lot conducted by the stewards or their representatives.

*f. Successful claims; later races.*

(1) Sale or transfer. No successful claimant may sell or transfer a horse, except in a claiming race, for a period of 30 days from the date of claim.

(2) Eligibility price. A horse claimed may not start in a race in which the claiming price is less than the amount for which it was claimed. After 30 days, a horse may start for any claiming price. This provision shall not apply to starter handicaps in which the weight to be carried is assigned by the handicapper or for starter allowances. No right, title, or interest for any claimed horse shall be sold or transferred except in a claiming race for a period of 30 days following the date of claiming. The day claimed shall not count, but the following calendar day shall be the first day.

(3) Racing elsewhere. A horse that was claimed under these rules may not participate at a race meeting other than that at which it was claimed until the end of the meeting, except with written permission of the stewards. This limitation shall not apply to stakes races.

(4) Same management. A claimed horse shall not remain in the same stable or under the control or management of its former owner.

(5) When a horse is claimed out of a claiming race, the horse's engagements are included.

*g. Transfer after claim.*

(1) Forms. Upon a successful claim, the stewards shall issue in triplicate, upon forms approved by the commission, an authorization of transfer of the horse from the original owner to the claimant. Copies of the transfer authorization shall be forwarded to and maintained by the commission, the stewards, and the racing secretary.

(2) No claimed horse shall be delivered by the original owner to the successful claimant until the claim is approved by the stewards. Every horse claimed shall race for the account of the original owner, but title to the horse shall be transferred to the claimant from the time the horse becomes a starter; and said successful claimant becomes the owner of the horse unless the claim is voided by the stewards under the provisions of this paragraph. Only a horse which is officially a starter in the race may be claimed. A subsequent disqualification of the horse by order of the stewards shall have no effect upon the claim.

(3) The stewards shall void the claim and return the horse to the original owner if:

1. The claimed horse suffers a fatality during the running of the race, dies, or is euthanized before leaving the track.

2. The commission veterinarian, during the veterinarian's observation of the horse coming off the track or upon its arrival to the test barn, determines the horse will be placed on the veterinarian's list as lame. The stewards shall not void the claim if, prior to the race in which the horse is claimed, the claimant elects to claim the horse regardless of whether the commission veterinarian determines the horse will be placed on the veterinarian's list as lame. An election made under this rule shall be entered on the claim form.

3. The race is called off, canceled, or declared no contest.

(4) Other-jurisdiction rules. The commission will recognize and be governed by the rules of any other jurisdiction regulating title and claiming races when ownership of a horse is transferred or affected by a claiming race conducted in that other jurisdiction.

(5) Determination of sex and age. The claimant, within 48 hours, shall be responsible for determining the age and sex of the horse claimed notwithstanding any designation of sex and age appearing in the program or in any racing publication. Horses that are spayed or gelded shall be properly identified as such in the program. If the claimant finds that a mare is in fact spayed or that the status of a male horse is inaccurate as stated by the program, the claimant may return the horse for full refund of the claiming price.

(6) Affidavit by claimant. The stewards may, if they determine it necessary, require any claimant to execute a sworn statement that the claimant is claiming the horse for the claimant's own account or as an authorized agent for a principal and not for any other person.

(7) Delivery required. No person shall refuse to deliver a properly claimed horse to the successful claimant. The claimed horse shall be disqualified from entering any race until delivery is made to the claimant.

(8) Obstructing the rules of claiming. No person or licensee shall obstruct or interfere with another person or licensee in claiming any horse, enter into any agreement with another to subvert or defeat the object and procedures of a claiming race, or attempt to prevent any horse entered from being claimed.

*h. Elimination of stable.* An owner whose stable has been eliminated by claiming may claim for the remainder of the meeting at which eliminated or for 30 racing days, whichever is longer. With the permission of the stewards, stables eliminated by fire or other casualty may claim under this rule.

*i. Disallowance of claim.* The stewards may cancel and disallow any claim within 24 hours after a race if they determine that a claim was made upon the basis of a lease, sale, or entry of a horse made for the purpose of fraudulently obtaining the privilege of making a claim; or if an eligible claimant improperly obtains information or access to horses by being present in the paddock during the claiming race unless the claimant has a horse in that claiming race, as determined solely by the stewards. In the event of a disallowance, the stewards may further order the return of a horse to its original owner and the return of all claim moneys. To disallow a claim, it must be shown by clear and convincing evidence that there is a direct and substantial connection between the eligible claimant and the owner or owner's trainer of the horse to be claimed wherein the eligible claimant improperly gained information about the horse to be claimed and the information was otherwise unavailable to other licensed owners or ownership entities. The mere appearance of impropriety is not a basis for disallowing a claim.

*j. Protest of claim.* A protest to any claim must be filed with the stewards before noon of the day following the date of the race in which the horse was claimed. Nonracing days are excluded from this rule. Should the stewards void a claim for reasons other than failure to follow the procedure for claiming, when there are multiple claims on a singular horse, said claim shall not be voided until after the determination by lot.

*k. Waived claiming rule.* At the time of entry into claiming races, the owner, trainer, or any authorized agent may opt to declare a horse ineligible to be claimed provided:

- (1) The horse has not been an official starter at any racetrack for a minimum of 120 days since the horse's last race as an official starter (at time of race);
- (2) The horse's last race as an official starter was one in which the horse was eligible to be claimed;
- (3) The horse is entered for a claiming price equal to or greater than the claiming price at which the horse last started as an official starter;
- (4) Failure of declaration of ineligibility at time of entry may not be remedied; and
- (5) Ineligibility to be claimed shall apply only to the horse's first start as an official starter following each such 120-day or longer layoff.

*l. Eligibility of in-foal filly or mare.* An in-foal filly or mare shall be eligible to be entered into a claiming race only if the following conditions are fulfilled:

- (1) Full disclosure of such fact is on file with the racing secretary and such information is posted in the secretary's office;
- (2) The stallion service certificate has been deposited with the racing secretary's office before the horse runs;
- (3) All payments due for the service in question and for any live progeny resulting from that service are paid in full;
- (4) The release of the stallion service certificate to the successful claimant at the time of claim is guaranteed; and
- (5) The cutoff for racing is 150 days of gestation.

**10.6(19) Quarter horse time trial races.**

*a.* Except in cases where the starting gate physically restricts the number of horses starting, each time trial shall consist of no more than ten horses.

*b.* The time trials shall be raced under the same conditions as the finals. If the time trials are conducted on the same day, the horses with the ten fastest times shall qualify to participate in the finals. If the time trials are conducted on two days, the horses with the five fastest times on the first day and the horses with the five fastest times on the second day shall qualify to participate in the finals. When time trials are conducted on two days, the racing office should make every attempt to split owners with more than one entry into separate days so that the owner's horses have a chance at all ten qualifying positions.

*c.* If the facility's starting gate has fewer than ten stalls, then the maximum number of qualifiers will correspond to the maximum number of starting gate post positions.

*d.* If only 11 or 12 horses are entered to run in time trials from a gate with 12 or more stalls, the facility may choose to run finals only. If 11 or 12 horses participate in the finals, only the first 10 finishers will receive purse money.

*e.* In the time trials, horses shall qualify on the basis of time and order of finish. The times of the horses in the time trial will be determined to the limit of the timer. The only exception is when two or more horses have the same time in the same trial heat. Then the order of finish shall also determine the preference in the horses' qualifying for the finals. Should two or more horses in different time trials have the same qualifying time to the limit of the timer for the final qualifying position(s), then a draw by public lot shall be conducted as directed by the stewards. Under no circumstances should stewards or placing judges attempt to determine horses' qualifying times in separate trials beyond the limit of the timer by comparing or enlarging a photo finish picture.

*f.* Except in the case of disqualification, under no circumstances shall a horse qualify ahead of a horse that finished ahead of that horse in the official order of finish in a time trial.

*g.* Should a horse be disqualified for interference during the running of a time trial, it shall receive the time of the horse it is immediately placed behind plus one hundredth of a second, or the maximum accuracy of the electronic timing device. No adjustments will be made in the times recorded in the time trials to account for headwind, tailwind, and off track. In the case where a horse is disqualified for interference with another horse causing loss of rider or the horse not to finish the race, the disqualified horse may be given no time plus one hundredth of a second, or the maximum accuracy of the electronic timing device.

*h.* Should a malfunction occur with an electronic timer on any time trial, finalists from that time trial will then be determined by official hand times operated by three official and disinterested persons. The average of the three hand times will be utilized for the winning time, unless one of the hand times is clearly incorrect. In such cases, the average of the two accurate hand times will be utilized for the winning time. The other horses in that race will be given times according to the order and margins of finish with the aid of the photo finish strip, if available.

*i.* When there is a malfunction of the timer during the time trials, but the timer operates correctly in other time trials, under no circumstances should the accurate electronic times be discarded and the average of the hand times used for all time trials. (The only exemption may be if the conditions of the stakes race so state, or state that, in the case of a malfunction of the timer in trials, finalists will be selected by order of finish in the trials.)

*j.* In the case where the accuracy of the electronic timer or the average of the hand times is questioned, the video of a time trial may be used to estimate the winning time by counting the number of video frames in the race from the moment the starting gate stall doors are fully open parallel to the racing track. This method is accurate to approximately .03 seconds. Should the case arise where the timer malfunctions and there are no hand times, the stewards have the option to select qualifiers based on the video time.

*k.* Should there be a malfunction of the starting gate and one or more stall doors not open or open after the exact moment when the starter dispatches the field, the stewards may declare the horses in stalls with malfunctioning doors to be nonstarters. The stewards should have the option, however, to allow any horse whose stall door opened late but still ran a time fast enough to qualify to be declared a starter for qualifying purposes. In the case where a horse breaks through the stall door or the stall door opens prior to the exact moment the starter dispatches the field, the horse must be declared a nonstarter and all entry fees refunded. In the case where one or more, but not all, stall doors open at the exact moment the

starter dispatches the field, these horses should be considered starters for qualifying purposes, and placed according to their electronic times. If the electronic timer malfunctions in this instance, the average of the hand times, or, if not available, the video time, should be utilized for the horses that were declared starters.

*l.* There will be an also eligible list only in the case of a disqualification for a positive drug test report, ineligibility of the horse according to the conditions of the race, or a disqualification by the stewards for a rule violation. Should a horse be disqualified for a positive drug test report, ineligibility of the horse according to the conditions of the race, or a disqualification by the stewards for a rule violation, the next fastest qualifier shall assume the disqualified horse's position in the finals.

*m.* If a horse should be scratched from the time trials, the horse's owner will not be eligible for a refund of the fees paid, and that horse will not be allowed to enter the finals under any circumstances. If a horse that qualified for the finals is unable to enter due to racing soundness or is scratched for any reason other than a positive drug test report or a rule violation, the horse shall be deemed to have earned, and the owner will receive, last place purse money. If more than one horse is scratched from the finals for any reason other than a positive drug test report or a rule violation, then the purse moneys shall be added together and divided equally among the owners.

[ARC 7757B, IAB 5/6/09, effective 6/10/09; ARC 9987B, IAB 2/8/12, effective 3/14/12; ARC 1876C, IAB 2/18/15, effective 3/25/15; ARC 2468C, IAB 3/30/16, effective 5/4/16; ARC 2927C, IAB 2/1/17, effective 3/8/17; ARC 3608C, IAB 1/31/18, effective 3/7/18; ARC 4378C, IAB 3/27/19, effective 5/1/19; ARC 4954C, IAB 2/26/20, effective 4/1/20; ARC 5423C, IAB 2/10/21, effective 3/17/21]

#### **491—10.7(99D) Medication and administration, sample collection, chemists, and practicing veterinarian.**

##### **10.7(1) Medication and administration.**

*a.* No horse, while participating in a race, shall carry in its body any medication, drug, foreign substance, or metabolic derivative thereof, which is a narcotic or which could serve as a local anesthetic or tranquilizer or which could stimulate or depress the circulatory, respiratory, or central nervous system of a horse, thereby affecting its speed.

*b.* Also prohibited are any drugs or foreign substances that might mask or screen the presence of the prohibited drugs, or prevent or delay testing procedures.

*c.* Proof of detection by the commission chemist of the presence of a medication, drug, foreign substance, or metabolic derivative thereof, prohibited by paragraph 10.7(1) "a" or "b," in a saliva, urine, blood, or hair sample duly taken under the supervision of the commission veterinarian from a horse immediately prior to or promptly after running in a race shall be prima facie evidence that the horse was administered, with the intent that it would carry or that it did carry in its body while running in a race, a prohibited medication, drug, or foreign substance in violation of this rule.

*d.* Administration or possession of drugs.

(1) No person shall administer, cause to be administered, or participate or attempt to participate in any way in the administration of any medication, drug, foreign substance, or treatment by any route to a horse registered for racing on the day of the race prior to the race in which the horse is entered.

(2) No person except a veterinarian shall have in the person's possession any prescription drug. Prescriptions shall be written or dispensed or both only by duly licensed veterinarians in the context of a valid veterinarian-client-patient relationship and based upon a specific medical diagnosis. However, a person may possess a noninjectable prescription drug for animal use if:

1. The person actually possesses, within the racetrack enclosure, documentary evidence that a prescription has been issued to said person for such a prescription drug.

2. The prescription contains a specific dosage for the particular horse or horses to be treated by the prescription drug.

3. The horse or horses named in the prescription are then in said person's care within the racetrack enclosure.

(3) No veterinarian or any other person shall have in their possession or administer to any horse within any racetrack enclosure any chemical or biological substance which:

1. Has not been approved for use on equines by the Food and Drug Administration pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. Section 301 et seq., and implementing regulations,

without the prior written approval from a commission veterinarian, after consulting with the board of stewards.

2. Is on any of the schedules of controlled substances as prepared by the Attorney General of the United States pursuant to 21 U.S.C. Sections 811 and 812, without the prior written approval from a commission veterinarian after consultation with the board of stewards. The commission veterinarian shall not give such approval unless the person seeking the approval can produce evidence in recognized veterinary journals or by recognized equine experts that such chemical substance has a beneficial therapeutic use in horses.

(4) No veterinarian or any other person shall dispense, sell, or furnish any feed supplement, tonic, veterinary preparation, medication, or any other substance that can be administered or applied to a horse by any route, to any person within the premises of the facility unless it is labeled in conformance with this rule or is otherwise labeled as required by law. A substance does not comply with this rule if the label is missing, illegible, tampered with, or altered.

1. Labels for all substances must include the name of the substance dispensed; the name of the dispensing person; the name of the horse or horses for which the substance is dispensed; the purpose for which the substance is dispensed; the dispensing veterinarian's recommendations for withdrawal before racing, if applicable; and the name of the person to whom dispensed.

2. Labels for medications or other prescribed substances must include all items from subparagraph 10.7(1) "d"(1) and, in addition, the date the prescription was filled; the name of the trainer or owner of the horse for whom the product was dispensed; dose; dosage; route of administration; duration of treatment of the prescribed product; and expiration date.

(5) No person shall have in the person's possession or in areas under said person's responsibility on facility premises any feed supplement, tonic, veterinary preparation, medication, or any substance that can be administered or applied to a horse by any route unless it complies with the labeling requirements in 10.7(1) "d"(4).

(6) No person shall possess, use, or distribute a compounded medication within the premises of the facility if there is a Food and Drug Administration-approved equivalent of that substance available for purchase unless approved by the commission veterinarian. Veterinary drugs shall be compounded in accordance with all applicable state and federal laws. Compounded medication shall be dispensed only by prescription issued by a licensed veterinarian to meet the medical needs of a specific horse and for use only in that specific horse. All compound medications must be labeled as required by law.

(7) Any drug or medication for horses which is used or kept on facility premises and which requires a prescription must be prescribed in compliance with applicable state law and regulations by a veterinarian who is duly licensed by the commission, the Iowa veterinary board, or the state in which the horse was located at the time of the examination, diagnosis and prescription.

*e.* Any person found to have administered, or caused, participated in, or attempted to participate in any way in the administration of a medication, drug, or foreign substance that caused or could have caused a violation of this rule shall be subject to disciplinary action.

*f.* The owner, trainer, groom, or any other person having charge, custody, or care of the horse is obligated to protect the horse properly and guard it against the administration or attempted administration of a substance in violation of this rule. If the stewards find that any person has failed to show proper protection and guarding of the horse, or if the stewards find that any owner, lessee, or trainer is guilty of negligence, they shall impose discipline and take other action they deem proper under any of the rules including referral to the commission.

*g.* In order for a horse to be placed on the bleeder list in Iowa through reciprocity, that horse must be certified as a bleeder in another state or jurisdiction. A certified bleeder is a horse that has raced with furosemide in another state or jurisdiction in compliance with the laws governing furosemide in that state or jurisdiction.

*h.* The possession or use of blood doping agents, including but not limited to those listed below, on the premises of a facility under the jurisdiction of the commission is forbidden:

- (1) Erythropoietin;
- (2) Darbepoetin;

(3) Oxyglobin®; and

(4) Hemopure®.

*i.* The use of extracorporeal shock wave therapy or radial pulse wave therapy shall not be permitted unless the following conditions are met:

(1) Any treated horse shall not be permitted to race for a minimum of ten days following treatment;

(2) The use of extracorporeal shock wave therapy or radial pulse wave therapy machines shall be limited to veterinarians licensed to practice by the commission;

(3) Any extracorporeal shock wave therapy or radial pulse wave therapy machines on the association grounds must be registered with and approved by the commission or its designee before use;

(4) All extracorporeal shock wave therapy or radial pulse wave therapy treatments must be reported to the official veterinarian on the prescribed form not later than the time prescribed by the official veterinarian.

*j.* The use of a nasogastric tube (a tube longer than six inches) for the administration of any substance within 24 hours prior to the post time of the race in which the horse is entered is prohibited without the prior permission of the official veterinarian or designee.

*k.* Non-steroidal anti-inflammatory drugs (NSAIDs).

(1) The use of one of three approved NSAIDs shall be permitted under the following conditions:

1. The level does not exceed the following permitted serum or plasma threshold concentrations which are consistent with administration by a single intravenous injection at least 24 hours before the post time for the race in which the horse is entered:

- Phenylbutazone (or its metabolite oxyphenylbutazone) – 2 micrograms per milliliter;
- Flunixin – 20 nanograms per milliliter;
- Ketoprofen – 2 nanograms per milliliter.

2. The NSAIDs listed in numbered paragraph “1” or any other NSAIDs are prohibited from being administered within the 24 hours before post time for the race in which the horse is entered.

3. The presence of more than one of the three approved NSAIDs, with the exception of phenylbutazone in a concentration below 0.3 micrograms per milliliter, flunixin in a concentration below 3 nanograms per milliliter, or ketoprofen in a concentration below 1 nanogram per milliliter of serum or plasma, or the presence of any unapproved NSAID in the post-race serum or plasma sample is not permitted. The use of all but one of the approved NSAIDs shall be discontinued at least 48 hours before the post time for the race in which the horse is entered.

(2) Any horse to which an NSAID has been administered shall be subject to having a blood sample(s), urine sample(s) or both taken at the direction of the official veterinarian to determine the quantitative NSAID level(s) or the presence of other drugs which may be present in the blood or urine sample(s).

**10.7(2) Sample collection.**

*a.* Under the supervision of the commission veterinarian, urine, blood, hair, and other specimens shall be taken and tested from any horse that the stewards, commission veterinarian, or the commission’s representatives may designate. The samples shall be collected by the commission veterinarian or other person or persons the commission may designate. Each sample shall be marked or numbered and bear information essential to its proper analysis; but the identity of the horse from which the sample was taken or the identity of its owners or trainer shall not be revealed to the official chemist or the staff of the chemist. The container of each sample shall be sealed as soon as the sample is placed therein.

*b.* A facility shall have a detention barn under the supervision of the commission veterinarian for the purpose of collecting body fluid samples for any tests required by the commission. The building, location, arrangement, furnishings, and facilities including refrigeration and hot and cold running water must be approved by the commission. A security guard, approved by the commission, must be in attendance at each access to the detention barn during the hours designated by the commission.

*c.* No unauthorized person shall be admitted at any time to the building or the area utilized for the purpose of collecting the required body fluid samples or the area designated for the retention of horses pending the obtaining of body fluid samples.

*d.* During the taking of samples from a horse, the owner, responsible trainer, or a representative designated by the owner or trainer may be present and witness the taking of the sample and so signify in writing. Failure to be present and witness the collection of the samples constitutes a waiver by the owner, trainer, or representative of any objections to the source and documentation of the sample.

*e.* The commission veterinarian, the board of stewards, agents of the division of criminal investigation, or commission representative may take samples of any medicine or other materials suspected of containing improper medication, drugs, or other substance which could affect the racing condition of a horse in a race, which may be found in barns or elsewhere on facility premises or in the possession of any person connected with racing, and the same shall be delivered to the official chemist for analysis.

*f.* Nothing in these rules shall be construed to prevent:

(1) Any horse in any race from being subjected by the order of a steward or the commission veterinarian to tests of body fluid samples for the purpose of determining the presence of any foreign substance.

(2) The state steward or the commission veterinarian from authorizing the splitting of any sample.

(3) The commission or commission veterinarian from requiring body fluid samples to be stored in a frozen state for future analysis.

*g.* Before leaving the racing surface, the trainer shall ascertain the testing status of the horse under the trainer's care from the commission veterinarian or designated detention barn representative.

#### **10.7(3) Chemists.**

*a.* Tests are to be under the supervision of the commission, which shall employ one or more chemists or contract with one or more qualified chemical laboratories to determine by chemical testing and analysis of body fluid samples whether a foreign substance, medication, drug or metabolic derivative thereof is present.

*b.* All body fluid samples taken by or under direction of the commission veterinarian or commission representative shall be delivered to the laboratory of the official chemist for analysis.

*c.* The commission chemist shall be responsible for safeguarding and testing each sample delivered to the laboratory by the commission veterinarian.

*d.* The commission chemist shall conduct individual tests on each sample, screening them for prohibited substances, and conducting other tests to detect and identify any suspected prohibited substance or metabolic derivative thereof with specificity. Pooling of samples shall be permitted only with the knowledge and approval of the commission.

*e.* Upon the finding of a test negative for prohibited substances, the remaining portions of the sample may be discarded. Upon the finding of a test suspicious or positive for prohibited substances, the test shall be reconfirmed and the remaining portion, if available, of the sample shall be preserved and protected for one year following close of meet.

*f.* The commission chemist shall submit to the commission a written report as to each sample tested, indicating by sample tag identification number, whether the sample was tested negative or positive for prohibited substances. The commission chemist shall report test findings to no person other than the administrator or commission representative, with the exception of notifying the state stewards of all positive tests.

*g.* In the event the commission chemist should find a sample suspicious for a prohibited medication, additional time for test analysis and confirmation may be requested.

*h.* In reporting to the state steward a finding of a test positive for a prohibited substance, the commission chemist shall present documentary or demonstrative evidence acceptable in the scientific community and admissible in court in support of the professional opinion as to the positive finding.

*i.* No action shall be taken by the state steward until an official report signed by the chemist properly identifying the medication, drug, or other substance as well as the horse from which the sample was taken has been received.

*j.* The cost of the testing and analysis shall be paid by the commission to the official chemist. The commission shall then be reimbursed by each facility on a per-sample basis so that each facility

shall bear only its proportion of the total cost of testing and analysis. The commission may first receive payment from funds provided in Iowa Code chapter 99D, if available.

**10.7(4) Practicing veterinarian.**

*a. Prohibited acts.*

(1) Ownership. A licensed veterinarian practicing at any meeting is prohibited from possessing any ownership, directly or indirectly, in any racing animal racing during the meeting.

(2) Wagering. Veterinarians licensed by the commission as veterinarians are prohibited from placing any wager of money or other thing of value directly or indirectly on the outcome of any race conducted at the meeting at which the veterinarian is furnishing professional service.

(3) Prohibition of furnishing injectable materials. No veterinarian shall within the facility premises furnish, sell, or loan any hypodermic syringe, needle, or other injection device, or any drug, narcotic, or prohibited substance to any other person unless with written permission of the stewards.

*b.* The use of other than single-use disposable syringes and infusion tubes on facility premises is prohibited. Whenever a veterinarian has used a hypodermic needle or syringe, the veterinarian shall destroy the needle and syringe and remove the needle and syringe from the facility premises.

*c.* Veterinarians must submit daily to the commission veterinarian on a prescribed form a report of all procedures, medications and other substances which the veterinarian prescribed, administered, or dispensed for racing animals registered at the current race meeting as provided in Iowa Code section 99D.25(10). Reports shall be submitted not later than noon the day following the treatments' being reported. Reports shall include the racing animal, trainer, procedure, medication or other substance, dosage or quantity, route of administration, date and time administered, dispensed, or prescribed. Reports shall be signed by the practicing veterinarian.

*d.* Practicing veterinarians shall not have contact with an entered horse within 24 hours before the scheduled post time of the race in which the horse is scheduled to compete unless approved by the state veterinarian except in the case of emergency. In case of an emergency, the state veterinarian must be notified prior to entering the stall. A documented attempt to contact the state veterinarian prior to entering the stall shall comply with the notification requirements pursuant to this rule. Any unauthorized contact may result in the horse's being scratched from the race in which it was scheduled to compete and may result in further disciplinary action by the stewards.

*e.* Each veterinarian shall report immediately to the commission veterinarian any illness presenting unusual or unknown symptoms in a racing animal entrusted into the veterinarian's care.

*f.* Practicing veterinarians may have employees licensed as veterinary assistants working under their direct supervision. Activities of these employees shall not include direct treatment or diagnosis of any animal. The practicing veterinarian must be present if a veterinary assistant is to have access to injection devices or injectables. The practicing veterinarian shall assume all responsibility for a veterinary assistant.

*g.* Equine dentistry is considered a function of veterinary practice by the Iowa veterinary practice Act. Any dental procedures performed at the facility must be performed by a licensed veterinarian or a licensed veterinary assistant.

[ARC 7757B, IAB 5/6/09, effective 6/10/09; ARC 2468C, IAB 3/30/16, effective 5/4/16; ARC 3446C, IAB 11/8/17, effective 12/13/17; ARC 3608C, IAB 1/31/18, effective 3/7/18; ARC 4194C, IAB 12/19/18, effective 1/23/19; ARC 4378C, IAB 3/27/19, effective 5/1/19]

These rules are intended to implement Iowa Code chapter 99D.

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<sup>0</sup> Two or more ARCs

<sup>1</sup> Effective date (1/4/89) of 10.4(14), 10.4(19)“b” and 10.6 delayed by the Administrative Rules Review Committee until January 9, 1989, at its December 13, 1988, meeting; effective date of January 4, 1989, delayed seventy days by this Committee at its January 5, 1989, meeting. Effective date delay lifted by the Committee at its February 13, 1989, meeting.

<sup>2</sup> Effective date of 10.6(2)“g”(3) second paragraph delayed until adjournment of the 1997 Session of the General Assembly by the Administrative Rules Review Committee at its meeting held October 8, 1996.

<sup>3</sup> June 19, 2013, effective date of 10.4(4)“a”(6) and 10.4(4)“d”(3)“1” [Items 17 and 18 of ARC 0734C, respectively] delayed until the adjournment of the 2014 General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2013.

CHAPTER 11  
GAMBLING GAMES

**491—11.1(99F) Definitions.**

“*Administrator*” means the administrator of the racing and gaming commission or the administrator’s designee.

“*Coin*” means tokens, nickels, and quarters of legal tender.

“*Commission*” means the racing and gaming commission.

“*Currency*” means any coin or paper money of legal tender and paper forms of cashless wagering.

“*Discount rate*” means either the current prime rate as published in the Wall Street Journal or a blended rate computed by obtaining quotes for the purchase of qualified investments at least three times per month.

“*Distributor’s license*” means a license issued by the administrator to any entity that sells, leases, or otherwise distributes gambling games or implements of gambling to any entity licensed to conduct gambling games pursuant to Iowa Code chapter 99F.

“*Facility*” means an entity licensed by the commission to conduct gaming operations in Iowa.

“*Facility grounds*” means all real property utilized by the facility in the conduct of its gaming activity, including the grandstand, concession stands, offices, parking lots, and any other areas under the jurisdiction of the commission.

“*Gambling game*” means any game of chance approved by the commission for wagering, including, but not limited to, gambling games authorized by this chapter.

“*Government sponsored enterprise debt instrument*” means a negotiable, senior, noncallable debt obligation issued by an agency of the United States or an entity sponsored by an agency of the United States that on the date of funding possesses an issuer credit rating equivalent to the highest investment grade rating given by Standard & Poor’s or Moody’s Investment Services.

“*Implement of gambling*” means any device or object determined by the administrator to directly or indirectly influence the outcome of a gambling game; collect wagering information while directly connected to a gambling game; facilitate the operation of an electronic wagering account as defined by rule 491—12.1(99F); or be integral to the conduct of a commission-authorized gambling game.

“*Independent financial institution*” means a bank approved to do business in the state of Iowa or an insurance company admitted to transact insurance in the state of Iowa with an A.M. Best insurance rating of “A” or other equivalent rating.

“*Manufacturer’s license*” means a license issued by the administrator to any entity that assembles, fabricates, produces, or otherwise constructs a gambling game or implement of gambling used in the conduct of gambling games pursuant to Iowa Code chapter 99F.

“*Present value*” means the current value of a future payment or series of payments, discounted using the discount rate.

“*Qualified investment*” means an Iowa state issued debt instrument, a United States Treasury debt instrument or a government sponsored enterprise debt obligation.

“*Reserve*” means an account with an independent financial institution or brokerage firm consisting of cash, qualified investments, or other secure funding method approved by the administrator used to satisfy periodic payments of prizes.

“*Slot machine*” means a mechanical or electronic gambling game device into which a player may deposit currency or forms of cashless wagering and from which certain numbers of credits are awarded when a particular configuration of symbols or events is displayed on the machine.

“*Storage media*” means EPROMs, ROMs, flash-ROMs, DVDs, CD-ROMs, compact flashes, hard drives and any other types of program storage device.

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**491—11.2(99F) Conduct of all gambling games.**

**11.2(1) Commission policy.** It is the policy of the commission to require that all facilities conduct gambling games in a manner suitable to protect the public health, safety, morals, good order, and general

welfare of the state. Responsibility for the employment and maintenance of suitable methods of operation rests with the facility. Willful or persistent use or toleration of methods of operation deemed unsuitable in the sole discretion of the commission will constitute grounds for disciplinary action, up to and including license revocation.

**11.2(2) *Activities prohibited.*** A facility is expressly prohibited from the following activities:

- a. Failing to conduct advertising and public relations activities in accordance with decency, dignity, good taste, and honesty.
- b. Permitting persons who are visibly intoxicated to participate in gaming activity.
- c. Failing to comply with or make provision for compliance with all federal, state, and local laws and rules pertaining to the operation of a facility including payment of license fees, withholding payroll taxes, and violations of alcoholic beverage laws or regulations.
- d. Possessing, or permitting to remain in or upon any facility grounds, any associated gambling equipment which may have in any manner been marked, tampered with, or otherwise placed in a condition or operated in a manner which might affect the game and its payouts.
- e. Permitting, if the facility was aware of, or should have been aware of, any cheating.
- f. Possessing or permitting to remain in or upon any facility grounds, if the facility was aware of, or should have been aware of, any cheating device whatsoever; or conducting, carrying on, operating, or dealing any cheating or thieving game or device on the grounds.
- g. Possessing or permitting to remain in or upon any facility grounds, if the facility was aware of, or should have been aware of, any gambling device which tends to alter the normal random selection of criteria which determines the results of the game or deceives the public in any way.
- h. Failing to conduct gaming operations in accordance with proper standards of custom, decorum, and decency; or permitting any type of conduct that reflects negatively on the state or acts as a detriment to the gaming industry.
- i. Denying a commissioner or commission representative, upon proper and lawful demand, information or access to inspect any portion of the gaming operation.

**11.2(3) *Gambling aids.*** No person shall use, or possess with the intent to use, any calculator, computer, or other electronic, electrical, or mechanical device that:

- a. Assists in projecting the outcome of a game.
- b. Keeps track of cards that have been dealt.
- c. Keeps track of changing probabilities.

**11.2(4) *Wagers.*** Wagers may only be made:

- a. By a person present at a facility.
- b. In the form of chips, coins, or other cashless wagering.
- c. By persons 21 years of age or older.

[ARC 8029B, IAB 8/12/09, effective 9/16/09]

**491—11.3(99F) *Gambling games approved by the commission.*** The commission may approve a gambling game by administrative rule, resolution, or motion.

**491—11.4(99F) *Approval for distribution, operation, or movement of gambling games and implements of gambling.***

**11.4(1) *Approval.*** Prior to distribution, a distributor shall request that the administrator inspect, investigate, and approve a gambling game or implement of gambling for compliance with commission rules and the standards required by a commission-designated independent testing facility. The distributor, at its own expense, must provide the administrator and independent testing facility with information and product sufficient to determine the integrity and security of the product, including independent testing conducted by a designated testing facility. The commission shall designate up to two independent testing facilities for the purpose of certifying electronic gambling games or implements of gambling.

**11.4(2) *Trial period.*** Prior to or after commission approval and after completing a review of a proposed gambling game, the administrator may require a trial period of up to 180 days to test the

gambling game in a facility. During the trial period, minor changes in the operation or design of the gambling game may be made with prior approval of the administrator. During the trial period, a gambling game distributor shall not be entitled to receive revenue of any kind from the operation of that gambling game.

**11.4(3) *Gambling game submissions.*** Prior to conducting a commission-authorized gambling game or for a trial period, a facility shall submit proposals for game rules, procedures, wagers, shuffling procedures, dealing procedures, cutting procedures, and payout odds. The gambling game submission, or requests for modification to an approved submission, shall be in writing and approved by the administrator or a commission representative prior to implementation.

**11.4(4) *Public notice.*** The public shall have access to the rules of play, payout schedules, and permitted wagering amounts. Signage shall be conspicuously posted on the gaming floor to direct patrons to the gaming floor area where this information can be viewed. All participants in all licensed gambling games are required to know and follow the rules of play. No forms of cheating shall be permitted.

**11.4(5) *Operation.*** Each gambling game shall operate and play in accordance with the representation made to the commission and the public at all times. The administrator or commission representative may order the withdrawal of any gambling game suspected of malfunction or misrepresentation, until all deficiencies are corrected. The administrator or commission representative may require additional testing by an independent testing facility at the expense of the licensee or distributor for the purpose of complying with this subrule.

**11.4(6) *Distribution, movement and disposal.***

*a.* Except as otherwise authorized by the administrator, written notice, submitted by facsimile or electronic mail, shall be filed with the commission when a gambling game or implement of gambling is shipped, moved or disposed of. The written notice shall be provided as follows:

(1) At least five calendar days prior to arrival of a gambling game or implement of gambling at a licensed facility, the licensed distributor shall provide notice.

(2) At least one day before a gambling game is removed from or disposed of by a licensed facility, the licensed facility or the owner shall provide notice. All methods of disposal for gambling games or implements of gambling are subject to administrator approval.

*b.* The administrator may approve licensee transfers of gambling games or implements of gambling among subsidiaries of the licensee's parent company.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10; ARC 1456C, IAB 5/14/14, effective 6/18/14]

#### **491—11.5(99F) Gambling games authorized.**

**11.5(1)** Craps, roulette, twenty-one (blackjack), baccarat, big six and poker are authorized as table games. The administrator is authorized to approve multiplayer electronic devices simulating these games, subject to the requirements of rule 491—11.4(99F) and subrule 11.5(3).

**11.5(2)** Slot machines, video poker, and other video games of chance, both progressive and nonprogressive, shall be allowed as slot machine games, subject to the administrator's approval of individual slot machine prototypes and game variations. For racetrack enclosures without a table games license, video machines which simulate table games of chance shall not be allowed.

**11.5(3)** The administrator is authorized to approve variations of approved gambling games and bonus features or progressive wagers associated with approved gambling games, subject to the requirements of rule 491—11.4(99F).

*a.* Features utilizing a controller or a system linked to gambling games that do not require direct monetary consideration and are not otherwise integrated within a slot machine game theme may be allowed as bonus features. Payouts from these bonus features may be included in winnings for the calculation of wagering tax adjusted gross receipts when the following conditions are met:

(1) The only allowable nonmonetary consideration to be expended by a participant shall be active participation in a gambling game with a bonus feature or use of a player's club card, or both.

(2) The actual bonus payout deductible in any month from all qualified system bonuses requiring no additional direct monetary consideration shall be:

1. No more than 2 percent of the coin-in for all slot machines linked to any system bonuses for that month, if slot machines linked to system bonuses exceed 20 percent of the total number of slot machines; or

2. No more than 3 percent of the coin-in for all slot machines linked to any system bonuses for that month, if slot machines linked to system bonuses are less than or equal to 20 percent of the total number of slot machines; or

3. No more than 3 percent of the amount wagered on the qualifying bets for all table games linked to any system bonus for that month.

(3) The probability of winning a system bonus award shall be the same for all persons participating in the bonus feature.

*b.* Noncashable credit payouts may be allowed as bonus feature payouts subject to the administrator's approval of individual accounting, expiration and redemption practices.

**11.5(4)** Gambling games of chance involving prizes awarded to participants through promotional activities at a facility may be conducted by the licensee providing the following:

*a.* Rules shall be made available to participants for review prior to registering. Rules shall include, at a minimum, all conditions registered players must meet to qualify to enter or participate in the event, available prizes or awards, and distribution of prizes or awards based on specific outcomes.

*b.* All gambling games are conducted in a fair and honest manner, and all rules are followed. Changes to rules shall not be made after participants have registered.

*c.* Results shall be made available for the registered players to review at the same location at which or in the same manner in which players registered. Results shall include, at a minimum, name of the event, date of the event, total number of entries, total prize pool, and amount paid for each winning category.

*d.* No entry fees shall be permitted.

*e.* All employees of the facility shall be prohibited from participation.

*f.* Such games shall be limited to participants 21 years of age or older.

*g.* There is compliance with all other federal, state and local laws and rules outside of the commission's jurisdiction.

*h.* Outcomes for gambling games shall be determined on the designated gaming floor, approved pursuant to 491—subrule 5.4(17), and outcomes shall be immediately or simultaneously displayed by a device or devices on the designated gaming floor.

*i.* In determining adjusted gross receipts pursuant to Iowa Code section 99F.11, the facility may consider all nonmonetary consideration expended by a participant and the nonmonetary consideration shall at least equal the value of prizes awarded.

**11.5(5)** Mechanical devices employing kickers or plates to direct coins, tokens or chips to fall over an edge into a payout hopper may be authorized as gambling games, subject to the following conditions:

*a.* All devices are subject to the requirements of rule 491—11.4(99F).

*b.* Devices shall accept no more than one coin, token or chip per play, unless otherwise authorized by the administrator.

*c.* Tokens or chips used in devices shall have a value defined by the facility. Each assigned value must be displayed on the device. Values are subject to approval by the administrator.

*d.* Merchandise, coins, tokens, chips or other legal tender may be added to the device at the discretion of the facility:

(1) Anything of value added to a device must be in accordance with the approval of the device under the requirements of rule 491—11.4(99F); and

(2) Anything of value added to a device shall be documented, and documentation shall be retained in accordance with the retention requirements of 491—subrule 5.4(14).

*e.* Any coins, tokens or chips collected by the facility or not returned to individuals wagering on a device shall be included as gross receipts for the calculation of wagering tax on adjusted gross receipts:

(1) When a device is removed from play, coins, tokens, chips or other legal tender that were added to the device may be used to offset gross receipts for the calculation of wagering tax on adjusted gross receipts; and

(2) Merchandise or other items of value added to a device shall not be considered in the calculation of wagering tax on adjusted gross receipts.

*f.* Merchandise, coins, tokens, chips or other legal tender shall not be removed from a device while it remains in operation, except as winnings to an individual from a wager, or as the result of internal mechanisms of the device for collecting revenue, approved in accordance with rule 491—11.4(99F).

*g.* Anything of value in the machine shall not be tampered with or adjusted while a device remains in operation, except as required to return a malfunctioning device to operation.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10; ARC 9987B, IAB 2/8/12, effective 3/14/12; ARC 0734C, IAB 5/15/13, effective 6/19/13; ARC 4378C, IAB 3/27/19, effective 5/1/19; ARC 4954C, IAB 2/26/20, effective 4/1/20; ARC 5422C, IAB 2/10/21, effective 3/17/21]

#### **491—11.6(99F) Gambling game-based tournaments.**

**11.6(1) Proposals.** Proposals for terms, game rules, entry fees, prizes, dates, and procedures must be submitted in writing and approved by a commission representative before a facility conducts any tournament. Any changes to approved tournaments must be submitted to the commission representative for review and approval prior to being implemented. The written proposal or change shall be submitted to a commission representative at least 14 days in advance of the planned activity. Rules, fees, and a schedule of prizes must be made available to the player prior to entry.

**11.6(2) Limits.** Tournaments must be based on gambling games authorized by the commission. Entry fees, less prizes paid, are subject to the wagering tax pursuant to Iowa Code section 99F.11. In determining adjusted gross receipts, to the extent that prizes paid out exceed entry fees received, the facility shall be deemed to have paid the fees for the participants.

**11.6(3) Tournament chips.** Tournament chips used as wagers in table game tournament proposals approved pursuant to this rule shall be imprinted with a number representing the value of the chip or shall be assigned a value. The facility shall provide that:

*a.* The assigned value of tournament chips be conspicuously displayed in the tournament area.

*b.* Internal controls which account for all tournament chips and include reconciliation, handling and variance procedures are approved by a commission representative.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9987B, IAB 2/8/12, effective 3/14/12]

#### **491—11.7(99F) Table game requirements.**

**11.7(1)** Devices that determine or affect the outcome of wagers or are used in the collection of wagers on table games are subject to the requirements of rule 491—11.4(99F) and subrule 11.5(3). Removable storage media shall be sealed with tamper-evident tape by a commission representative prior to implementation.

**11.7(2) Wagers.**

*a.* All wagers at table games shall be made by placing gaming chips or coins on the appropriate areas of the layout or by making a cashless wager using an approved wagering device.

*b.* Information pertaining to the minimum and maximum allowed at the table shall be posted on the game.

*c.* A facility may impose an aggregate payout limit on a per round basis for approved table game odds payouts that are greater than 50 to 1. If imposed, aggregate limits shall be at least the highest available award at the posted minimum bet, or \$25,000, whichever amount is greater, and the amount shall be posted on the game. When applying the aggregate payout limit to multiple players' wins, facilities shall calculate each player's win as a pro rata share of the aggregate payout limit. Alternate aggregate or individual player payout limits may be established, as determined by the administrator.

*d.* Any other fee collected to participate in a table game shall be subject to the wagering tax pursuant to Iowa Code section 99F.11.

**11.7(3) Craps.**

*a.* Wagers must be made before the dice are thrown. “Call bets,” or the calling out of bets between the time the dice leave the shooter’s hand and the time the dice come to rest, not accompanied by the placement of gaming chips, are not allowed. A wager made on any bet may be removed or reduced at any time prior to a roll that decides the outcome of such wager unless the wager is a “Pass” or “Come” bet and a point has been established with respect to such bet or the wager is a proposition bet contingent on multiple rolls.

*b.* The shooter shall make a “Pass” or “Don’t Pass” bet and shall handle the two selected dice with one hand before throwing the dice in a simultaneous manner.

*c.* Each die used shall be transparent.

**11.7(4) Twenty-one.**

*a.* Before the first card is dealt for each round of play, each player shall make a wager against the dealer. Once the first card of any hand has been dealt by the dealer, no player shall handle, remove, or alter any wagers that have been made until a decision has been rendered and implemented with respect to that wager. Once a wager on the insurance line, a wager to double down, or a wager to split pairs has been made and confirmed by the dealer, no player shall handle, remove, or alter the wagers until a decision has been rendered and implemented with respect to that wager, except as explicitly permitted. A facility or licensee shall not permit any player to engage in conduct that violates this paragraph.

*b.* At the conclusion of a round of play, all cards still remaining on the layout shall be picked up by the dealer in a prescribed order and in such a way that they can be readily arranged to indicate each player’s hand in case of question or dispute. The dealer shall pick up the cards beginning with those of the player to the far right and moving counterclockwise around the table. The dealer’s hand will be the last hand collected. The cards will then be placed on top of the discard pile. No player or spectator shall remove or alter any cards used to game at twenty-one or be permitted to do so by a casino employee.

*c.* Each player at the table shall be responsible for correctly computing the point count of the player’s hand. No player shall rely on the point counts announced by the dealer without checking the accuracy of such announcement.

**11.7(5) Roulette.**

*a.* No person at a roulette table shall be issued or permitted to game with nonvalue gaming chips that are identical in color and design to value gaming chips or to nonvalue gaming chips being used by another person at that same table.

*b.* Each player shall be responsible for the correct positioning of the player’s wager on the roulette layout, regardless of whether the player is assisted by the dealer. Each player must ensure that any instructions the player gives to the dealer regarding the placement of the player’s wager are correctly carried out.

*c.* Each wager shall be settled strictly in accordance with its position on the layout when the ball falls to rest in a compartment of the wheel.

**11.7(6) Big six.**

*a.* Wagers must be made before the spin of the wheel.

*b.* Each player shall be responsible for the correct positioning of the player’s wager on the layout regardless of whether that player is assisted by the dealer.

*c.* The wheel may be spun in either direction, but must complete at least three revolutions to be considered a valid spin.

*d.* Each wager shall be settled strictly in accordance with its position on the layout when the wheel stops with the winning indicator in a compartment of the wheel. In accordance with subrule 11.4(3), the rules shall include procedures addressing wheel stops that land between two compartments of the wheel. These procedures shall be posted at the game.

**11.7(7) Poker.**

*a.* When a facility conducts poker with an imprest dealer gaming chip bank, the rules in 491—Chapter 12 for closing and distributing or removing gaming chips to or from gaming tables do not apply. The entire amount of the table rake is subject to the wagering tax pursuant to Iowa Code section 99F.11. Proposals for imprest dealer gaming chip banks must be submitted in writing and approved by

a commission representative prior to use and must include, but not be limited to, controls to regularly monitor, investigate, and report table bank variances.

*b.* All games shall be played according to table stakes game rules as follows:

(1) Only gaming chips or coins on the table at the start of a deal shall be in play for that pot.

(2) Concealed gaming chips or coins shall not play.

(3) A player with gaming chips may add additional gaming chips between deals, provided that the player complies with any minimum buy-in requirement.

(4) A player is never obliged to drop out of contention because of insufficient gaming chips to call the full amount of a bet, but may call for the amount of gaming chips the player has on the table. The excess part of the bet made by other players is either returned to the players or used to form a side pot.

*c.* Each player in a poker game is required to act only in the player's own best interest. The facility has the responsibility of ensuring that any behavior designed to assist one player over another is prohibited. The facility may prohibit any two players from playing in the same game.

*d.* Poker games where winning wagers are paid by the facility according to specific payout odds or pay tables are permitted.

*e.* The facility shall comply with and receive approval pursuant to subrule 11.4(3) for each type of poker game offered.

*f.* The facility may elect to offer a jackpot award generated from pot contributions at a table or group of tables for predesignated high-value poker hands, subject to the following requirements:

(1) Approval of the jackpot award rules must be obtained from a commission representative prior to play.

(2) Jackpot award rules and jackpot award amounts shall be posted in a conspicuous location within the poker room. Jackpot award amounts shall be updated no less than once per day.

(3) The facility shall divide pot contributions for any single qualifying award circumstance or event into no more than three jackpot award pools.

(4) The jackpot award pool containing the highest monetary value amount shall be the amount posted in the poker room and awarded to a qualifying player or players.

(5) If additional jackpot award pools are in use, the award pool containing the highest monetary value shall be used to seed the primary jackpot award pool.

(6) All moneys collected as pot contributions to a jackpot award payout shall be distributed in their entirety to the players; no facility shall charge an administration fee for distribution of a jackpot award.

**11.7(8) Baccarat.** Before the first card is dealt for each round of play, each player is permitted to make a wager on the Banker's Hand, Player's Hand, Tie Bet, and any proposition bet if offered. All wagers shall be made by placing gaming chips on the appropriate areas of the layout. Once the first card has been dealt by the dealer, no player shall handle, remove, or alter any wagers that have been made until a decision has been rendered and implemented with respect to that wager.

**11.7(9) Preverified cards.** Cards that are verified prior to arrival at the facility may be approved by the administrator for use in table games authorized by this rule. Preverified cards may be shuffled or sequenced according to the licensee's specifications. Each manufacturer of preverified cards shall request approval of its cards, pursuant to subrule 11.4(1), and is subject to the following additional requirements:

*a.* Each device used to verify or automate the randomization of the cards before they are shipped to a licensee shall be certified by a commission-designated independent testing facility.

*b.* The manufacturer shall develop and submit to the administrator a process for producing, shuffling, and packaging preverified cards that includes the following:

(1) A visual inspection of the back of each card, ensuring the cards are not flawed or marked in any way that might compromise the integrity of the gambling game.

(2) A verification that each package of cards contains the correct number of suits and cards in accordance with the commission-approved rules of the game for the game with which the package of cards is intended for use.

(3) Insertion of the cards in a package with a tamper-evident seal that bears conspicuous indication if the package has been opened. The exterior of the package shall indicate:

1. The total number of decks contained within the package.

2. The commission-authorized game with which the cards are intended for use.
3. The color of the cards within the package.
- (4) Generation of a receipt in the package or a label on the sealed package to include the following information:
  1. The total number of cards and decks contained within the package.
  2. The date and time the cards were shuffled, verified and packaged.
  3. Information sufficient to determine the specific details regarding any persons or devices involved in the production, verification or packaging of the cards.

[ARC 9987B, IAB 2/8/12, effective 3/14/12; ARC 2927C, IAB 2/1/17, effective 3/8/17; ARC 3608C, IAB 1/31/18, effective 3/7/18; ARC 5422C, IAB 2/10/21, effective 3/17/21]

#### **491—11.8(99F) Keno.**

**11.8(1)** Keno shall be conducted using an automated ticket writing and redemption system where a game's winning numbers are selected by a random number generator.

**11.8(2)** Each game shall consist of the selection of 20 numbers out of 80 possible numbers, 1 through 80.

**11.8(3)** For any type of wager offered, the payout must be at least 70 percent.

**11.8(4)** Multigame tickets shall be limited to 20 games.

**11.8(5)** Writing or voiding tickets for a game after that game has closed is prohibited.

**11.8(6)** All winning tickets shall be valid up to a maximum of one year from the date of purchase. All expired, unclaimed winning tickets shall be subject to the requirements in 491—paragraph 12.11(2) "b."

**11.8(7)** The administrator shall determine minimum hardware and software requirements to ensure the integrity of play. An automated keno system must be proven to accurately account for adjusted gross receipts to the satisfaction of the administrator.

**11.8(8)** Adjusted gross receipts from keno games shall be the difference between dollar value of tickets written and dollar value of winning tickets as determined from the automated keno system. The wagering tax pursuant to Iowa Code section 99F.11 shall apply to adjusted gross receipts of keno games.

**11.8(9)** An area of a facility shall not be designated as gaming floor for the sole purpose of keno runners, who accept patron wagering funds remotely from the keno game location.

[ARC 9018B, IAB 8/25/10, effective 9/29/10]

#### **491—11.9(99F) Slot machine requirements.**

**11.9(1)** *Payout percentage.* A slot machine game must meet the following maximum and minimum theoretical percentage payouts during the expected lifetime of the game.

*a.* A slot machine game's theoretical payout must be at least 80 percent and no more than 100 percent of the amount wagered. The theoretical payout percentage is determined using standard methods of probability theory. Slot machine games with a bonus feature that is available with varying payouts based on the player's ability shall be allowed if the difference between the minimum and maximum payout for all ability-based outcomes does not exceed a 4 percent contribution to the overall theoretical payout of the slot machine game.

*b.* A slot machine game shall have a probability of obtaining the highest single advertised payout, which must statistically occur at least once in 50 million games.

**11.9(2)** *Features.* Unless otherwise authorized by the administrator, each slot machine in a casino shall have the following features:

*a.* A casino number at least two inches in height permanently imprinted, affixed, or impressed on the outside of the machine so that the number may be observed by the surveillance camera.

*b.* A clear description displayed on the slot machine of any merchandise or thing of value offered as a payout including the cash equivalent value of the merchandise or thing of value offered, the dates the merchandise or thing of value will be offered if the facility establishes a time limit upon initially offering the merchandise or thing of value, and the availability or unavailability to the patron of the optional cash equivalent value. A cash equivalent value shall be at least 75 percent of the fair market value of the merchandise or thing of value offered.

c. Devices, equipment, features, and capabilities, as may be required by the commission, that are specific to each slot machine after the prototype model is approved by the commission.

**11.9(3) Storage media.** Hardware media devices which contain game functions or characteristics, including but not limited to pay tables and random number generators, shall be verified and sealed with evidence tape by a commission representative prior to being placed in operation, as determined by the administrator.

**11.9(4) Posting of the actual aggregate payout percentage.** The actual aggregate payout percentage to the nearest one-tenth of 1 percent (0.1%) of all slot machine games in operation during the preceding three calendar months shall be posted at the main casino entrance, cashier cages, and slot booths by the fifteenth day of each calendar month. For the purpose of this calculation, the actual aggregate payout percentage shall be the slot revenue reported to the commission during the preceding three calendar months divided by the slot coin-in reported to the commission during the preceding three calendar months subtracted from 100 percent.

**11.9(5) Communication equipment.** Equipment must be installed in each slot machine that allows for communication to an online monitoring and control system accessible, with read-only access, to the commission representatives using a communications protocol provided to each licensed manufacturer by the commission for the information and control programs approved by the administrator.

**11.9(6) Meter clears.** Prior to the clearing of electronic accounting meters detailed in paragraph 11.10(2) "c," a licensee must notify a commission representative. All meters recorded by the game must be retained according to the requirements in 491—subrule 5.4(14).

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10]

#### **491—11.10(99F) Slot machine hardware and software specifications.**

##### **11.10(1) Hardware specifications.**

a. Electrical and mechanical parts and design principles shall not subject players to physical hazards.

b. The battery backup, or an equivalent, for the electronic meters must be capable of maintaining accuracy of all required information for 30 days after power is discontinued from a slot machine. The backup shall be kept within the locked logic board compartment.

c. An identification badge permanently affixed by the manufacturer to the exterior of the cabinet shall include the following information:

- (1) The manufacturer;
- (2) A unique serial number;
- (3) The gaming device model number; and
- (4) The date of manufacture.

d. The operations and outcomes of each slot machine must not be adversely affected by influences from outside the device.

e. The internal space of a slot machine shall not be readily accessible when the front door is both closed and locked.

f. Logic boards and software storage media which significantly influence the operation of the game must be in a locked compartment within the slot machine.

g. The currency drop container must be in a locked compartment within or attached to the slot machine. Access to the currency storage areas shall be secured by separate locks which shall be fitted with sensors that indicate door open/closed or stacker removed.

h. No hardware switches may be installed that alter the pay tables or payout percentages in the operation of a slot machine. Hardware switches may be installed to control graphic routines, speed of play, and sound.

i. A display which automatically illuminates when a player has won a jackpot or other award not paid automatically and totally by the slot machine and which advises players that they will be paid by an attendant shall be located conspicuously on the slot machine.

j. A payglass/video display shall be clearly identified and shall accurately state the rules of the game and the award that will be paid to the player when the player obtains a specific combination of

symbols or other criteria. All information required in this paragraph must be available and readable at all times the slot machine is in service.

*k.* A light that automatically illuminates when a player has won an amount or is redeeming credits that the machine cannot automatically pay, an error condition has occurred, or a “Call attendant” condition has been initiated by the player shall be located conspicuously on top of the gaming device. At the discretion of the administrator, tower lights may be shared among certain machines or substituted by an audible alarm.

*l.* If credits are collected and the total credit value is unable to be paid automatically by the gaming device, the device shall lock up until the credits have been paid and the amount collected has been cleared by an attendant handpay or normal operation has been restored.

**11.10(2) Software specifications.**

*a. Random number generator.* Each slot machine must have a random number generator to determine the results of the game symbol selections or production of game outcomes. The selection shall:

- (1) Be statistically independent.
- (2) Conform to the desired random distribution.
- (3) Pass various recognized statistical tests.
- (4) Be unpredictable.
- (5) Have a testing confidence level of 99 percent.

*b. Continuation of game after malfunction is cleared.* Each slot machine must be capable of continuing the current game with all current game features after a malfunction is cleared. This paragraph does not apply if a slot machine is rendered totally inoperable; however, the current wager and all credits appearing on the screen prior to the malfunction must be returned to the player.

*c. Electronic accounting meters.* Each slot machine must maintain electronic accounting meters at all times, regardless of whether the slot machine is being supplied with power. For each meter recording values, the slot machine must be capable of maintaining no fewer than ten digits. For each meter recording occurrences, the slot machine must be capable of maintaining no fewer than eight digits. No slot machine may have a mechanism that will cause the electronic accounting meters to automatically clear due to an error. The electronic meters must record, at a minimum, the following:

- (1) Coin-in.
- (2) Coin-out.
- (3) Drop.
- (4) Attendant-paid jackpots.
- (5) Currency in.
- (6) Currency out.
- (7) External door.
- (8) Bill validator door.
- (9) Machine-paid external bonus payout.
- (10) Attendant-paid external bonus payout.
- (11) Attendant-paid progressive payout.
- (12) Machine-paid progressive payout.

*d. Error conditions.* Each slot machine shall display and report error conditions to the online monitoring system. For machines that display only a code, definitions for all codes must be permanently affixed to the interior of the slot machine. Error conditions that must be displayed and reported include but are not limited to:

- (1) Currency in.
- (2) Currency out.
- (3) Door open.
- (4) RAM.
- (5) Low battery.
- (6) Program authentication.
- (7) Reel spin.

(8) Power reset.

**11.10(3) Previous slot machine models.** Subject to administrator approval of specific gaming devices, slot machines may be used that do not meet the requirements of subrules 11.10(1) and 11.10(2) but have been certified under previously approved specifications by a commission-designated independent testing facility and maintain a current certification.

[ARC 8029B, IAB 8/12/09, effective 9/16/09]

**491—11.11(99F) Slot machine specifications.** Rescinded IAB 8/12/09, effective 9/16/09.

**491—11.12(99F) Progressive slot machines.**

**11.12(1) Meter required.** A progressive machine is a slot machine game with an award amount that increases based on a function of credits bet on the slot machine and that is awarded when a particular configuration of symbols or events is displayed on the slot machine. Random events generating awards independent of the base slot machine game and not dependent on any specific slot machine game shall be considered bonus features. A progressive slot machine or group of linked progressive slot machines must have a meter showing the progressive jackpot payout.

**11.12(2) Progressive controllers.** The reset or base value and the rate of increment of a progressive jackpot game must be filed with a commission representative prior to implementation. A reset or base value must equal or exceed the equivalent nonprogressive jackpot payout.

**11.12(3) Limits.** A facility may impose a limit on the progressive jackpot payout of a slot machine if the limit imposed is greater than the progressive jackpot payout at the time the limit is imposed. The facility must prominently display a notice informing the public of the limit. No progressive meter may be turned back to a lesser amount unless one of the following circumstances occurs:

- a. The amount shown on the progressive meter is paid to a player as a jackpot.
- b. It is necessary to adjust the progressive meter to prevent it from displaying an amount greater than the limit imposed by the facility.
- c. It is necessary to change the progressive indicator because of game malfunction.

**11.12(4) Transfer of jackpots.** In the event of malfunction, replacement, or other reason approved by the commission, a progressive jackpot that is removed shall be transferred, less the reset value, to other progressive slot machine jackpots of similar progressive wager and probability at the same facility within 30 days from the removal date. In the event a similar progressive jackpot at the same facility is unavailable, other transfers shall be allowed. A commission representative shall be notified in writing prior to a removal or transfer.

**11.12(5) Records required.** Records must be maintained that record the amount shown on a progressive jackpot meter. Supporting documents must be maintained to explain any reduction in the payoff amount from a previous entry. The records and documents must be retained for a period of three years unless permission to destroy them earlier is given in writing by the administrator.

**11.12(6) Transfer of progressive slot machines.** A progressive slot machine, upon permission of the administrator, may be moved to a different facility if a bankruptcy, loss of license, or other good cause warrants.

**11.12(7) Linked machines.** Each machine on the link shall have the same probability of winning the progressive jackpot, adjusted for the total amount wagered. The probability of winning the progressive jackpot multiplied by the maximum amount wagered shall be within the maximum allowable tolerance for all games on the link. For the purpose of this calculation, the maximum allowable tolerance when linked with any other game shall be the product of the probability of winning the progressive jackpot, adjusted for amount wagered, multiplied by:

- a. 1 percent (0.01) for games where the probability of winning the progressive jackpot is less frequent than or equal to 1 in 100,000; or
- b. 5 percent (0.05) for games where the probability of winning the progressive jackpot is more frequent than 1 in 100,000.

**11.12(8) Wide area progressive systems.** A wide area progressive system is a method of linking progressive slot machines or electronic gaming machines by secured data communication as part of a

network that connects participating facilities. The purpose of a wide area progressive system is to offer a common progressive jackpot (system jackpot) at all participating locations within Iowa or in multiple states. The operation of a wide area progressive system (multilink) is permitted, subject to the following conditions:

*a.* The provider of a multilink (provider) shall be an entity licensed as a manufacturer, a distributor, or an operator of gambling games within the state of Iowa or be the qualified parent company of an operator of gambling games within the state of Iowa. No entity shall be licensed for the sole purpose of providing a multilink.

*b.* Prior to operation of a multilink, the provider shall submit to the administrator for review and approval information sufficient to determine the integrity and security of the multilink. The information must include, but is not limited to, the following:

- (1) Central system site location, specifications, and operational procedures.
- (2) Encryption and method of secured communication over the multilink and between facilities.
- (3) Method and process for obtaining meter data from slot machines on the multilink.
- (4) Disbursement options for jackpot payoffs, including information for periodic payments.

Periodic payment information, including number of payments and time between payments must be displayed as part of the slot machine pay table or prominently displayed on the face of the slot machine.

(5) Jackpot contribution rates, including information sufficient to determine contributions to the jackpot are consistent across all entities participating in the multilink. Any subsequent changes to the contribution rate of a multilink jackpot must be submitted to the administrator for review and approval.

(6) Jackpot verification procedures.

(7) Jackpot discontinuation procedures, including procedures for distribution of contributions to another jackpot or return of pro rata shares to participating facilities.

*c.* The provider of the multilink shall, upon request, supply reports and information to the administrator which detail the contributions and economic activity of the system, subject to the following requirements:

(1) Aggregate and detail reports that show both the economic activity of the entire multilink, as well as details of each machine on the multilink.

(2) Upon invoicing a facility, details regarding each machine at the facility and each machine's contribution to the multilink for the period of the invoice shall be supplied, as well as any other details required by the administrator.

*d.* Concurrent jackpots which occur before the multilink jackpot meters show reset and updated jackpot amounts will be deemed to have occurred simultaneously. Each winner shall receive the full amount shown on the system jackpot meter.

*e.* The provider must suspend play on the multilink if a communication failure of the system cannot be corrected within 24 consecutive hours.

*f.* A meter that shows the amount of the system jackpot must be conspicuously displayed at or near the machines to which the jackpot applies. Jackpot meters may show amounts that differ from the actual system jackpot, due to delays in communication between sites and the central system, but meters shall not display an incorrect amount for an awarded jackpot.

*g.* In calculating adjusted gross receipts, a facility may deduct its pro rata share of the present value of any system jackpots awarded. Such deduction shall be listed on the detailed accounting records supplied by the provider. A facility's pro rata share is based on the amount of coin-in from that facility's machines on the multilink, compared to the total amount of coin-in on the whole system for the time period between awarded jackpots.

*h.* In the event a facility ceases operations and a progressive jackpot is awarded subsequent to the last day of the final month of operation, the facility may not file an amended wagering tax submission or make a claim for a wagering tax refund based on its contributions to that particular progressive prize pool.

*i.* The payment of any system jackpot offered on a multilink shall be administered by the provider, and the provider shall have sole liability for payment of any system jackpot the provider administers.

*j.* The provider shall comply with the following:

(1) A reserve shall be established and maintained by the provider in an amount of not less than the sum of the following amounts:

1. The present value of the amount currently reflected on the jackpot meters of the multilink.
2. The present value of one additional reset (start amount) of the multilink.

(2) For system jackpots disbursed in periodic payments, a provider shall fund the periodic payments within 90 days of the notice of the jackpot award with:

1. Purchase of a qualified investment. A copy of such qualified investment shall be provided to the administrator within 30 days of purchase. Any qualified investment shall have a surrender value at maturity, excluding any interest paid before the maturity date, equal to or greater than the value of the corresponding periodic jackpot payment and shall have a maturity date prior to the date the periodic jackpot payment is required to be made; or

2. A surety bond or an irrevocable letter of credit with an independent financial institution which provides periodic payments to a winner should the establishment default for any reason. The written agreement establishing a surety bond or irrevocable letter of credit shall be submitted to the administrator within 30 days of purchase; or

3. An irrevocable trust with an independent financial institution in accordance with a written trust agreement approved by the administrator which provides periodic payments from an unallocated pool of assets to a group of winners and which shall expressly prohibit the winner from encumbering, assigning or otherwise transferring in any way the winner's right to receive the deferred portion of the winnings except to the winner's estate. The assets of the trust shall consist of federal government securities including but not limited to treasury bills, treasury bonds, savings bonds or other federally guaranteed securities in an amount sufficient to meet the periodic payments as required; or

4. Another irrevocable method of providing the periodic payments to a winning player consistent with the purpose of this subparagraph, and which is approved by the administrator prior to implementation.

(3) The provider shall not be permitted to sell, trade, or otherwise dispose of any periodic payment funding unless approval to do so is first obtained from the administrator.

(4) Upon becoming aware of an event of noncompliance with the terms of the reserve requirement mandated by subparagraph 11.12(8) "j"(1) above, or in the event of nonpayment of a periodic payment directly by the provider, the provider must immediately notify the administrator. An event of noncompliance includes a nonpayment of a jackpot periodic payment or a circumstance which may cause the provider to be unable to fulfill, or which may otherwise impair the provider's ability to satisfy, the provider's jackpot payment obligations.

(5) On a quarterly basis, the provider must deliver to the administrator a calculation of system reserves required under subparagraph 11.12(8) "j"(1) above. The calculation shall come with a certification of financial compliance signed by a duly authorized financial officer of the provider, on a form prescribed by the administrator, validating the calculation.

(6) On an annual basis, the provider must deliver to the administrator updated information sufficient to determine compliance with the funding requirements of all outstanding periodic payments. This shall include an updated listing of all winners showing outstanding periodic payment amounts and any updates to funding documents and agreements. The updated information shall come with a certification of compliance signed by a duly authorized financial officer of the provider.

(7) The reserve required under subparagraph 11.12(8) "j"(1) must be examined by an independent certified public accountant according to procedures approved by the administrator. Two copies of the report must be submitted to the administrator within 90 days after the conclusion of the provider's fiscal year.

(8) The administrator may require additional information or audits at any time to ensure compliance with this paragraph.

*k.* For system jackpots disbursed in periodic payments, subsequent to the date of the win, a winner may be offered the option to receive, in lieu of periodic payments, a discounted single cash payment in the form of a "qualified prize option," as that term is defined in Section 451(h) of the Internal Revenue Code. The provider shall calculate the single cash payment based on the discount rate. Until the new

discount rate becomes effective, the discount rate selected by the provider shall be used to calculate the single cash payment for all qualified prizes that occur subsequent to the date of the selected discount rate.

*l.* Multilinks to be offered in conjunction with jurisdictions in other states within the United States are permitted. Multistate multilinks are subject to the requirements of this subrule; in addition, any multistate plans or controls are subject to administrator review and approval.

[ARC 7757B, IAB 5/6/09, effective 6/10/09; ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10; ARC 1876C, IAB 2/18/15, effective 3/25/15; ARC 2927C, IAB 2/1/17, effective 3/8/17; ARC 4378C, IAB 3/27/19, effective 5/1/19]

#### **491—11.13(99F) Licensing of manufacturers and distributors of gambling games or implements of gambling.**

**11.13(1) *Impact on gambling.*** In considering whether a manufacturer or distributor applicant will be licensed or a specific product will be distributed, the administrator shall give due consideration to the economic impact of the applicant's product, the willingness of a licensed facility to offer the product to the public, and whether its revenue potential warrants the investigative time and effort required to maintain effective control over the product.

**11.13(2) *Licensing standards.*** Standards which shall be considered when determining the qualifications of an applicant shall include, but are not limited to, financial stability; business ability and experience; good character and reputation of the applicant as well as all directors, officers, partners, and employees; integrity of financial backers; and any effect on the Iowa economy.

**11.13(3) *Application procedure.*** Application for a manufacturer's or a distributor's license shall be made to the commission for approval by the administrator. In addition to the application, the following must be completed and presented when the application is filed:

*a.* Disclosure of ownership interest, directors, or officers of licensees.

(1) An applicant or licensee shall notify the administrator of the identity of each director, corporate officer, owner, partner, joint venture participant, trustee, or any other person who has any beneficial interest of 5 percent or more, direct or indirect, in the business entity. For any of the above, as required by the administrator, the applicant or licensee shall submit background information on forms supplied by the division of criminal investigation and any other information the administrator may require.

For purposes of this rule, beneficial interest includes all direct and indirect forms of ownership or control, voting power, or investment power held through any contract, lien, lease, partnership, stockholding, syndication, joint venture, understanding, relationship (including family relationship), present or reversionary right, title or interest, or otherwise.

(2) For ownership interests of less than 5 percent, the administrator may request a list of these interests. The list shall include names, percentages owned, addresses, social security numbers, and dates of birth. The administrator may request the same information required of those individuals in subparagraph (1) above.

*b.* Investigative fees.

(1) Advance payment. The department of public safety may request payment of the investigative fee in advance as a condition to beginning investigation.

(2) Payment required. The administrator may withhold final action with respect to any application until all investigative fees have been paid in full.

*c.* A bank or cashier's check made payable to the Iowa Racing and Gaming Commission for the annual license fee as follows:

(1) A manufacturer's license shall be \$250.

(2) A distributor's license shall be \$1,000.

*d.* A copy of each of the following:

(1) Articles of incorporation and certificate of incorporation, if the business entity is a corporation.

(2) Partnership agreement, if the business entity is a partnership.

(3) Trust agreement, if the business entity is a trust.

(4) Joint venture agreement, if the business entity is a joint venture.

(5) List of employees of the aforementioned who may have contact with persons within the state of Iowa.

*e.* A copy of each of the following types of proposed distribution agreements, where applicable:

- (1) Purchase agreement(s).
- (2) Lease agreement(s).
- (3) Bill(s) of sale.
- (4) Participation agreement(s).

*f.* Supplementary information. Each applicant shall promptly furnish the administrator with all additional information pertaining to the application or the applicant which the administrator may require. Failure to supply the information requested within five days after the request has been received by the applicant shall constitute grounds for delaying consideration of the application.

*g.* Any and all changes in the applicant's legal structure, directors, officers, or the respective ownership interests must be promptly filed with the administrator.

*h.* The administrator may deny, suspend, or revoke the license of an applicant or licensee in which a director, corporate officer, or holder of a beneficial interest includes or involves any person or entity which would be, or is, ineligible in any respect, such as through want of character, moral fitness, financial responsibility, professional qualifications, or due to failure to meet other criteria employed by the administrator, to participate in gaming regardless of the percentage of ownership interest involved. The administrator may order the ineligible person or entity to terminate all relationships with the licensee or applicant, including divestiture of any ownership interest or beneficial interest at acquisition cost.

*i.* Disclosure. Disclosure of the full nature and extent of all beneficial interests may be requested by the administrator and shall include the names of individuals and entities, the nature of their relationships, and the exact nature of their beneficial interest.

*j.* Public disclosure. Disclosure is made for the benefit of the public, and all documents pertaining to the ownership filed with the administrator shall be available for public inspection.

**11.13(4) Temporary license certificates.**

*a.* A temporary license certificate may be issued at the discretion of the administrator.

*b.* Temporary licenses—period valid. Any certificate issued at the discretion of the administrator shall be valid for a maximum of 120 calendar days from the date of issue.

Failure to obtain a permanent license within the designated time may result in revocation of the license eligibility, fine, or suspension.

**11.13(5) Withdrawal of application.** A written notice of withdrawal of application may be filed by an applicant at any time prior to final action. No application shall be permitted to be withdrawn unless the administrator determines the withdrawal to be in the public interest. No fee or other payment relating to any application shall become refundable by reason of withdrawal of the application.

**11.13(6) Record keeping.**

*a.* *Record storage required.* Distributors and manufacturers shall maintain adequate records of business operations, which shall be made available to the administrator upon request. These records shall include:

- (1) All correspondence with the administrator and other governmental agencies on the local, state, and federal level.
- (2) All correspondence between the licensee and any of its customers who are applicants or licensees under Iowa Code chapter 99F.
- (3) A personnel file on each employee of the licensee, including sales representatives.
- (4) Financial records of all transactions with facilities and all other licensees under these regulations.

*b.* *Record retention.* The records listed in 11.13(6)“a” shall be retained as required by 491—subrule 5.4(14).

**11.13(7) Violation of laws or regulations.** Violation of any provision of any laws of the state or of the United States of America or of any rules of the commission may constitute an unsuitable method of operation, subjecting the licensee to limiting, conditioning, restricting, revoking or suspending the license, or fining the licensee, or any combination of the above.

**11.13(8)** *Consent to inspections, searches, and seizures.* Each manufacturer or distributor licensed under this chapter shall consent to inspections, searches, and seizures deemed necessary by the administrator and authorized by law in order to enforce licensing requirements.

These rules are intended to implement Iowa Code chapter 99F.

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CHAPTER 12  
ACCOUNTING AND CASH CONTROL

**491—12.1(99F) Definitions.**

“*Casino*” means all areas of a facility where gaming is conducted.

“*Coin*” means tokens, nickels, and quarters of legal tender.

“*Commission*” means the racing and gaming commission.

“*Container*” means:

1. A box attached to a gaming table in which shall be deposited all currency in exchange for gaming chips, fill and credit slips, requests for fill forms, and table inventory forms.

2. A canister in a slot machine cabinet in which currency is retained by slot machines and not used to make change or automatic jackpot payouts.

“*Count room*” means an area in the facility where contents of containers are counted and recorded.

“*Currency*” means any coin or paper money of legal tender and paper forms of cashless wagering.

“*Drop*” means removing the containers from the casino to the count room.

“*Electronic wagering account*” means an individual player’s account established by an authorized facility into which a player can deposit funds for the purpose of wagering on authorized gambling devices.

“*Facility*” means an entity licensed by the commission to conduct gaming operations in Iowa.

“*Hopper*” means a payout reserve container in which coins are retained by a slot machine to automatically pay jackpots.

“*Internal controls*” means the facility’s system of internal controls.

“*Request*” means a request for credit slip, request for fill slip, or request for jackpot payout slip.

“*Slip*” means a credit slip, fill slip, or jackpot payout slip.

“*Slot machine*” means a mechanical or electronic gambling game device into which a player may deposit currency or other forms of cashless wagering and from which certain numbers of credits are awarded when a particular configuration of symbols or events is displayed on the machine.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 5422C, IAB 2/10/21, effective 3/17/21]

**491—12.2(99F) Accounting records.**

**12.2(1)** Each facility shall maintain complete and accurate records of all transactions pertaining to revenues and costs.

**12.2(2)** General accounting records shall be maintained on a double entry system of accounting with transactions recorded on an accrual basis.

**12.2(3)** Detailed, supporting, and subsidiary records shall be maintained. The records shall include, but are not limited to:

- a. Statistical game records by gaming day to reflect drop and win amounts by table for each game.
- b. Records of all investments, advances, loans, and receivable balances due the facility.
- c. Records related to investments in property and equipment.
- d. Records which identify the handle, payout, win amounts and percentages, theoretical win amounts and percentages; and differences between theoretical and actual win amounts and percentages for each slot machine on a week-to-date, month-to-date, and year-to-date basis.
- e. Records of all loans and other amounts payable by the facility.
- f. Records that identify the purchase, receipt, and disposal of gaming chips and tokens. All methods of disposal are subject to administrator approval.

**12.2(4)** Whenever forms or serial numbers are required to be accounted for or copies of forms are required to be compared for agreement and exceptions are noted, irreconcilable gambling revenue exceptions shall be reported immediately and in writing to the commission. All other exceptions shall be recorded in a log, accessible to commission representatives, maintained according to the requirements in 491—subrule 5.4(14).

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10]

**491—12.3(99F) Facility internal controls.**

**12.3(1)** Each facility shall submit a description of internal controls to the commission. The submission shall be made at least 90 days before gaming operations are to commence unless otherwise directed by the administrator. The submission shall include and provide for the following:

*a.* Administrative control that includes, but is not limited to, the plan of organization and the procedures and records that are concerned with the decision processes leading to management's levels of authorization of transactions.

*b.* Accounting control that includes the plan of organization and the procedures and records that are concerned with the safeguarding of assets and the reliability of financial records. The accounting control shall be designed to provide reasonable assurance that:

(1) Transactions are executed in accordance with management's general and specific authorization, which shall be consistent with the requirements of this chapter.

(2) Transactions are recorded as necessary to permit preparation of financial statements in conformity with generally accepted accounting principles and to maintain accountability for assets.

(3) Access to assets is permitted only in accordance with management authorization, which shall be consistent with the requirements of this chapter.

(4) The recorded accountability for assets is compared with existing assets at reasonable intervals and appropriate action is taken with respect to any differences.

*c.* Competent personnel with integrity and an understanding of prescribed internal controls.

*d.* The segregation of incompatible functions so that no employee is in a position to perpetrate and conceal errors or irregularities in the normal course of the employee's duties.

*e.* Surveillance internal controls that include:

(1) Surveillance departments that shall be operated in an autonomous fashion, as separate and distinct entities from all other departments. A gaming facility's organizational structure shall place the director of the surveillance department directly under the span of control and authority of the operator's board of directors or appropriate parent company executive where practical. Under no circumstances will the director of surveillance report to or take direction from any authority at a level below the general manager.

(2) Administration of the network for the purpose of utilizing and transmitting live or recorded views or images of a video surveillance system for asset protection, loss prevention, investigation of tort/liability claims, game protection, employee oversight, resolution of patron disputes, corporate governance, management analysis, or other use consistent with a licensee's statutory responsibilities as approved by the administrator.

(3) A system maintenance plan that includes management of:

1. Installations, changes, movements, and malfunctions;

2. A log of available and completed system upgrades, updates, and patches, including descriptions;

3. Universal power supply (UPS) capability, live video and recording redundancies;

4. Electrical outages, emergency evacuation, providing alternative coverage of dedicated areas for DCI approval; and

5. Job descriptions and training of employees responsible for system maintenance, and any external maintenance agreements.

*f.* Game control, including but not limited to procedures for the storage, removal and record of implements of gambling. The gaming control shall be designed to document:

(1) Access to implements of gambling not in use.

(2) Method for removal of implements of gambling from an active gambling game.

(3) Procedures governing the record of total inventory of implements of gambling, documenting both additions to and removal from storage and active use.

*g.* Preverified card control, for use with cards approved pursuant to 491—subrule 11.7(9). Controls shall be designed to document:

(1) The procedure governing inspection of the packaging when the cards are put into use on a live table game, including verification of the tamper-evident seal and review of the manufacturer-generated receipt for relevant details.

(2) The procedure for employee breaking of the tamper-evident seal to sign the receipt with name, time the package is being placed in use, and specific table where the package is being used.

(3) The procedure and period to retain the receipt and the details of use. The period of retention must correspond with records maintained by the manufacturer of the cards in accordance with the process submitted pursuant to 491—paragraph 11.7(9)“b.”

(4) Any additional procedures that will be used to verify or randomize preverified cards prior to play.

**12.3(2)** A commission representative shall review each submission required by subrule 12.3(1) and determine whether it conforms to the requirements of Iowa Code chapter 99F and is consistent with the intent of this chapter and whether the internal controls submitted provide adequate and effective control for the operations of the facility. If the commission representative finds any insufficiencies, the insufficiencies shall be specified in writing to the facility, which shall make appropriate alterations. No facility shall commence gaming operations unless and until the internal controls are approved.

**12.3(3)** Each facility shall submit to the commission any changes to the internal controls previously approved at least 15 days before the changes are to become effective unless otherwise directed by a commission representative. The proposed changes shall be submitted to the commission and the changes may be approved or disapproved by the commission representative. No facility shall alter its internal controls until the changes are approved.

**12.3(4)** It shall be the affirmative responsibility and continuing duty of each occupational licensee to follow and comply with all internal controls.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10; ARC 2927C, IAB 2/1/17, effective 3/8/17; ARC 4378C, IAB 3/27/19, effective 5/1/19; ARC 4954C, IAB 2/26/20, effective 4/1/20]

#### **491—12.4(99F) Accounting controls within the cashier’s cage.**

**12.4(1)** The assets for which the cashiers are responsible shall be maintained on an imprest basis. At the end of each shift, the cashiers assigned to the outgoing shift shall record on a cashier’s count sheet the face value of each cage inventory item counted and the total of the opening and closing cage inventories and shall reconcile the total closing inventory with the total opening inventory.

**12.4(2)** At the conclusion of gaming activity each gaming day, a copy of the cashiers’ count sheets and related documentation shall be forwarded to the accounting department for agreement of opening and closing inventories; agreement of amounts thereon to other forms, records, and documents required by this chapter; and the recording of all transactions.

**12.4(3)** Each facility shall place on file with the commission the names of all persons authorized to enter the cashier’s cage and persons who possess the combination or keys to the locks securing the entrance to the cage.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 3608C, IAB 1/31/18, effective 3/7/18]

**491—12.5(99F) Gaming table container.** Each gaming table in a casino shall have attached to it a container.

**12.5(1)** Each container shall have:

*a.* A lock securing the contents of the container, the key to which shall be logged out by the count team.

*b.* A separate lock securing the container to the gaming table, the key to which shall be different from the key in paragraph 12.5(1)“a” and shall be logged out by the drop team, count team, or emergency drop personnel pursuant to subrule 12.13(1).

*c.* A slot opening through which currency, forms, records, and documents can be inserted.

*d.* A mechanical device that will close and lock the slot opening upon removal of the container from the gaming table.

**12.5(2)** Keys referred to in this rule shall be maintained and controlled in a secured area by the security department. The facility shall establish a sign-out procedure for all keys removed from the secured area.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10]

**491—12.6(99F) Accepting currency at gaming tables.** Whenever currency is presented by a patron at a gaming table in exchange for gaming chips, the following procedures and requirements shall be observed:

**12.6(1)** The dealer or boxperson accepting the currency shall spread the currency on the top of the gaming table.

**12.6(2)** The dealer or boxperson shall verbalize the currency value in a tone of voice necessary to be heard by the patron and the casino supervisor assigned to the gaming table.

**12.6(3)** The dealer or boxperson shall take the currency from the top of the gaming table and place it into the container immediately after verbalizing the amount.

[ARC 8029B, IAB 8/12/09, effective 9/16/09]

**491—12.7(99F) Procedures for the movement of gaming chips to and from gaming tables.**

**12.7(1) Slips.** Each slip shall be sequentially numbered, shall be simultaneously printed in two or three copies, and shall discharge in the cashier's cage. Casino supervisors or casino clerks shall input data for each slip, and each prepared copy shall contain the following information:

- a. The type of transfer.
- b. The sequentially ordered slip number.
- c. The date and time of preparation.
- d. The total amount of each denomination.
- e. The total amount of all denominations.
- f. The game and table number.

**12.7(2) Distribution of chips to a gaming table.** On receipt of a slip in the cashier's cage for distribution of gaming chips to a table, the following procedures shall apply:

a. A cashier shall prepare the gaming chips and sign all copies of the slip attesting to the accuracy of the totals.

b. A security employee, or other employee authorized by the internal controls, shall compare the slip to the gaming chips prepared and sign all copies of the slip attesting to the accuracy. One copy of the slip shall remain with the cashier, if applicable, while two copies are transported with the gaming chips to the gaming table.

c. The dealer or boxperson assigned to the gaming table and the casino supervisor assigned to the gaming table shall sign all copies of the slip attesting to the accuracy of the fill.

d. Upon verification and placement of the gaming chips, the employee responsible for transporting the chips to the gaming table shall observe as the dealer or boxperson places one copy of the slip in the container of the gaming table. The employee shall then transport the remaining copy of the slip to the cashier's cage to be maintained and controlled by a cashier.

**12.7(3) Removal of chips from a gaming table.** On receipt of a slip in the cashier's cage for removal of gaming chips from a table, the following procedures shall apply:

a. A security employee, or other employee authorized by the internal controls, shall transfer all copies of the slip to the gaming table.

b. The dealer or boxperson assigned to the gaming table and the casino supervisor assigned to the gaming table shall prepare the removal and sign all copies of the slip attesting to the accuracy.

c. The security employee, or other employee authorized by internal controls, shall compare the slip to the gaming chips prepared and sign all copies of the slip attesting to the accuracy.

d. One copy of the slip shall be immediately placed in the container of the gaming table from which the gaming chips were removed.

e. The security employee, or other employee authorized by internal controls, shall transport the chips and the remaining copy of the slip to the cashier's cage.

f. The cashier shall compare this copy of the slip to the gaming chips received and shall sign the copy attesting to the accuracy. This copy of the slip shall be maintained and controlled by the cashier.

**12.7(4) Slip reconciliation.** At the end of each gaming day, copies of each of the slips maintained by the cashier's cage shall be forwarded to the accounting department for agreement with the copies of

the slips obtained by the count team from the gaming table containers. Copies shall also be compared for agreement with the stored data.

**12.7(5) *Stored data.*** All information required by subrule 12.7(1) shall be stored in machine-readable format. The stored data shall not be susceptible to change or removal by any personnel after preparation of a slip.

**12.7(6) *Manual process.*** In the event the online monitoring and control system is unavailable, the facility staff shall perform transfers of gaming chips to and from gaming tables using manual requests and slips.

*a.* Requests shall be prepared by the casino supervisor or casino clerk. For the distribution of chips to the gaming table, the request shall be signed by the security employee, or other employee authorized by the internal controls, and shall be left with the cashier prior to the transfer of gaming chips and slips required by paragraph 12.7(6) “*b.*” For the removal of chips from the gaming table, the request shall be signed at the gaming table by the security employee, or other employee authorized by the internal controls, prior to the transfer of gaming chips and slips required by paragraph 12.7(6) “*b.*” and shall be placed in the container when the slip signed by the cashier has been returned to the gaming table.

*b.* Slips shall be prepared by cashiers in the cage using a three-part serially prenumbered form in a locked dispenser. The dispenser shall discharge two copies of the slip that have been filled out and signed by the cashier and shall retain the third copy in a continuous form in the dispenser. The same procedures shall be followed and the same set of signatures shall be utilized as required by subrules 12.7(2) and 12.7(3).

*c.* The copies remaining in the dispenser shall be removed each gaming day where a manual process had to be performed for gaming chip movements and to replace the stored data used pursuant to subrule 12.7(4). Access to the locked dispenser shall be maintained and controlled by independent employees responsible for accounting for the unused slips, placing slips in the dispensers, and removing slips from the dispensers.

**12.7(7) *Modifications.*** Modifications to the procedures described in subrules 12.7(2), 12.7(3), and 12.7(4) may be substituted as internal controls, subject to the approval process of subrule 12.3(2), if the procedures comply with the intent of this rule.

**12.7(8) *Voided transactions.*** Whenever it becomes necessary to void a slip, all copies shall be clearly marked “void” and shall require the signature of the preparer. All void slips shall be maintained and controlled in conformity with subrules 12.7(2), 12.7(3), and 12.7(5).

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 1876C, IAB 2/18/15, effective 3/25/15]

#### **491—12.8(99F) Dropping or opening a gaming table.**

**12.8(1)** The table inventory slips shall be a two-part form, a “closer” and an “opener,” containing the following:

- a.* The date and time of preparation.
- b.* The game and table number.
- c.* The total value of each denomination of gaming chips.
- d.* The total value of all denominations of gaming chips.

**12.8(2)** Whenever a gaming table is dropped or upon initial opening after a drop, the gaming chips at the gaming table shall be counted by the dealer or boxperson assigned to the gaming table while observed by a casino supervisor assigned to the gaming table.

**12.8(3)** Signatures attesting to the accuracy of the information recorded on the table inventory slips at the time of dropping or opening of the gaming tables shall be of the dealer or boxperson and the casino supervisor assigned to the gaming table who observed the dealer or boxperson count the contents of the table inventory.

**12.8(4)** Upon meeting the signature requirements described in subrule 12.8(3):

*a.* The closer, at dropping, shall be deposited in the container immediately prior to the closing of the table. The opener and the gaming chips remaining at the table shall be placed in a secured, locked area on the table.

*b.* The opener, at opening, shall be immediately deposited in the container.

**12.8(5)** Upon opening a gaming table, if the totals on the gaming inventory form vary from the opening count, the casino supervisor shall fill out an error notification slip. The casino supervisor and dealer or boxperson shall sign the error notification slip and deposit the slip in the container.  
[ARC 8029B, IAB 8/12/09, effective 9/16/09]

**491—12.9(99F) Slot machine container and key.** Each slot machine shall have a container(s) that is housed in a locked compartment(s) separate from any other compartment of the slot machine.

**12.9(1)** Each container shall:

- a. Have a lock securing the contents of the container, the key to which shall be logged out by the count team or employees authorized by the internal controls to address container malfunction issues.
- b. Have a lock to each compartment securing the container to the slot machine, the key to which shall be different from the key in paragraph 12.9(1)“a” and shall be logged out by the drop team, employees authorized by the internal controls to address container malfunction issues, or employees transporting container(s) according to rule 491—12.13(99F).
- c. Be identified at the time of removal by a number corresponding to the number of the slot machine from which the container is removed.

**12.9(2)** Keys referred to in subrule 12.9(1) shall be maintained and controlled by the security department in a secured area. The facility shall establish a log-out procedure for all keys removed from the secured area.

**12.9(3)** Other keys to each slot machine or any device connected thereto which may affect the operation of the slot machine shall be maintained in a secure place and controlled by the slot department.  
[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10]

**491—12.10(99F) Procedures for hopper fills and attendant payouts.**

**12.10(1) Slips.** Each slip shall be sequentially numbered, and two copies shall be simultaneously printed. An employee authorized by the internal controls shall input data for each slip, and each prepared copy shall contain the following information:

- a. The type of transaction.
- b. The sequentially ordered slip number.
- c. The date and time of preparation.
- d. For attendant payouts, the amount to be paid and the cage location from which the amount is to be paid.
- e. For jackpots, the winning combination to be paid.
- f. For hopper fills, the denomination and amount of currency to be distributed.

**12.10(2) Hopper fills.** A slip shall be prepared by a person authorized by the internal controls whenever a slot machine fill is required. On receipt or preparation of a slip in the cashier’s cage, the following procedures shall apply:

- a. The cashier, upon providing the coins to an employee authorized by the internal controls, shall sign all copies of the slip attesting to the accuracy of the amount provided and the information contained on the slip.
- b. The employee authorized by the internal controls, upon receipt of the coins, shall sign all copies of the slip and transport the coins and one copy of the slip to the slot machine. The remaining copy shall remain with the cashier.
- c. An additional employee authorized by the internal controls, other than the employees listed in paragraphs 12.10(2)“a” and 12.10(2)“b,” shall observe the deposit of the coins into the slot machine hopper and the closing and locking of the slot machine door. This employee shall then sign the copy of the slip at the slot machine.
- d. Upon completion of the fill, the copy of the slip at the slot machine shall be deposited in a secure area controlled by the accounting department.

**12.10(3) Attendant payouts.** Whenever a patron wins a jackpot or has accumulated credits not totally and automatically paid directly from a slot machine, a slip shall be prepared by a person authorized by the internal controls. On receipt or preparation of a slip for an attendant payout in the cashier’s cage, the following procedures shall apply:

a. The cashier, upon providing the payment to an employee authorized by the internal controls, shall sign all copies of the slip attesting to the accuracy of the amount provided and the information contained on the slip.

b. The employee authorized by the internal controls, upon receipt of the payment, shall sign all copies of the slip and transport the payment and one copy of the slip to the slot machine. The remaining copy of the slip shall remain with the cashier.

c. An additional employee authorized by the internal controls, other than the employees listed in paragraphs 12.10(3) "a" and 12.10(3) "b," shall observe the payment of the patron. For jackpots, the employee shall verify the symbols on the slot machine. For jackpots in excess of \$10,000, the employee shall be a supervisor or higher authority. In either case, the employee shall then sign the copy of the slip at the slot machine.

d. Upon completion of the payout, the copy of the slip at the slot machine shall be deposited in a secure area controlled by the accounting department.

e. For a slot machine jackpot in excess of \$100,000, a facility shall notify a commission representative in accordance with the immediate notification process established by 491—subrule 5.4(5).

**12.10(4) Overrides.** System overrides shall be authorized by a slot supervisor or an employee authorized by the internal controls. This employee shall not perform the duties and signature requirements of subrules 12.10(2) and 12.10(3) in any transaction where the employee authorizes a system override. In addition to the signature requirements of subrules 12.10(2) and 12.10(3), the signature of the authorizing employee shall be on all copies of the slip.

**12.10(5) Slip reconciliation.** At the end of each gaming day, copies of the slip retained by the cashier's cage shall be forwarded to the accounting department for agreement with the copies of the slips deposited in the area controlled by the accounting department and for recording on the slot win sheet. Copies shall also be compared for agreement with the stored data.

**12.10(6) Stored data.** All information required by subrule 12.10(1) shall be stored in the online monitoring and control system in machine-readable format. The stored data shall not be susceptible to change or removal by any personnel after preparation of the slip.

**12.10(7) Modifications.** Modifications to the procedures described in subrules 12.10(2) to 12.10(5) may be substituted as internal controls, subject to the approval process of subrule 12.3(2), if the procedures comply with the intent of this rule.

**12.10(8) Manual process.** In the event the online monitoring and control system is unavailable, the facility staff shall perform hopper fills and manual payouts using manual slips. Manual slips shall be three-part serially prenumbered forms. For use of manual slips, the following shall apply:

a. Slips shall be placed in a locked dispenser. Once prepared, the dispenser shall discharge two copies of the slip, while retaining the third copy in a continuous form. They shall be prepared in the cashier's cage at the request of an employee authorized by the internal controls. Procedures for the two dispensed copies shall follow subrules 12.10(2) and 12.10(3).

b. The copies remaining in the dispenser shall be removed each gaming day where a manual process had to be performed for hopper fills or manual payouts and to replace the stored data used pursuant to subrule 12.10(5). Access to the locked dispenser shall be maintained and controlled by independent employees responsible for accounting for the unused slips, placing slips in the dispensers, and removing slips from the dispensers.

**12.10(9) Voided transactions.** Whenever it becomes necessary to void a slip, all the copies shall be clearly marked "void" and shall require the signature of the preparer. All void slips shall be maintained and controlled in conformity with subrules 12.10(2) to 12.10(5).

[ARC 8029B, IAB 8/12/09, effective 9/16/09]

#### **491—12.11(99F) Attendant and ticket payout accounting.**

**12.11(1) Attendant payouts.** Under this rule, unless otherwise subject to Iowa Code chapter 556, jackpots and accumulated credits paid by a slip that are unpaid or unclaimed at the close of a facility's fiscal year shall be disallowed as a deduction from gross receipts for the calculation of adjusted gross

revenue for the wagering tax. A facility shall make this adjustment to revenue within 90 days of the close of the facility's fiscal year.

**12.11(2) Ticket payouts.** Payouts dispensed by a ticket issued directly from a gaming device must have a minimum payout redemption period of 90 days from the date of issuance.

*a.* Notwithstanding 491—subrule 5.4(14), an issued ticket redeemed for cash or deposited in a slot machine for machine credits shall be retained for a minimum of 90 days from the redemption date. The ticket may be subsequently destroyed if record of the transaction is retrievable by other means.

*b.* At the close of the facility's fiscal year, tickets issued in previous fiscal years and tickets with expired redemption periods that remain outstanding and unredeemed are subject to the requirements of subrule 12.11(1).

[ARC 8029B, IAB 8/12/09, effective 9/16/09]

#### **491—12.12(99F) Computer recording requirements and monitoring of slot machines.**

**12.12(1)** A facility shall have an online monitoring and control system connected to each slot machine in the casino to record and monitor the slot machine's activities.

**12.12(2)** The online monitoring and control system shall be designed and operated to automatically perform the functions relating to slot machine meters in the casino as follows:

*a.* Record the number and total of currency placed in the slot machine for the purpose of activating play.

*b.* Record the number and total of currency in the container(s).

*c.* Record the number and total of currency to be paid manually as the result of a jackpot.

*d.* Record the electronic meter information required by 491—paragraph 11.10(2)“c.”

**12.12(3)** The online monitoring and control system shall monitor and detect machine exception codes and error messages as required by 491—paragraph 11.10(2)“d.”

**12.12(4)** The online monitoring and control system shall store in machine-readable form all information required by subrules 12.12(2) and 12.12(3), and the stored data shall not be susceptible to change or removal.

**12.12(5)** The licensee shall maintain a current log, accessible to commission representatives, of all changes and updates made to the online monitoring and control system that affect any part of the system's message digest. These changes and updates shall be approved as required by 491—subrule 11.4(1).

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10]

#### **491—12.13(99F) Transportation of containers.**

**12.13(1)** Each facility shall place on file with a commission representative a schedule setting forth the specific times at which the containers will be brought to or removed from the gaming tables or slot machines for transport to the count room. An emergency drop that deviates from the schedule shall be permissible for instances of full containers or container malfunctions provided that representatives from the security department and another department conduct the drop and the process is recorded by the surveillance department from the time of machine entry until the container is secured in the count room or other approved secure location. The commission representative shall be notified after each occurrence.

**12.13(2)** A security employee shall accompany and observe the drop team. For table games, all containers removed from the gaming tables shall be transported by a security employee and a table game supervisor.

**12.13(3)** All containers removed from slot machine cabinets shall:

*a.* Be removed by a drop team wearing uniforms or outer garments as required by subrule 12.15(2).

*b.* Be replaced immediately with an empty container that shall be secured in the cabinet.

**12.13(4)** All containers removed shall be transported directly to, and secured in, the count room or in a secure area within the facility until the containers can be transferred to the count room.

**12.13(5)** Empty containers not secured to the gaming tables or slot machine compartment shall be stored in the count room or an approved secured location. Empty containers may be removed from the count room or secured area for repair or destruction provided the surveillance department is notified and the inside of the container is held up to the full view of a closed circuit television camera prior to removal.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10]

**491—12.14(99F) Count room—characteristics.**

**12.14(1)** Each facility shall have a count room that shall:

*a.* Be designed and constructed to provide maximum security for materials housed within and the activities conducted therein.

*b.* Have an alarm device connected to the entrance of the room that causes a signaling to the monitors of the closed circuit surveillance system and to the commission representative's office whenever the door to the room is opened.

*c.* Have, if currency is counted within the count room, a count table constructed of clear glass or similar material for the emptying, counting, and recording of the contents of containers.

**12.14(2)** All room keys shall be maintained and controlled in a secured area by the security department. The facility shall establish a sign-out procedure for all keys removed from the secured area. [ARC 8029B, IAB 8/12/09, effective 9/16/09]

**491—12.15(99F) Opening, counting, and recording contents of containers in the count room.**

**12.15(1)** Each facility shall file with a commission representative the specific times and procedures for opening, counting, and recording the contents of containers.

**12.15(2)** All persons present in the count room during the counting process, unless expressly exempted by a commission representative, shall wear a full-length, one-piece, pocketless outer garment with openings only for the arms, feet, and neck that extends over any other garments and covers the tops of any footwear.

**12.15(3)** Persons shall not:

*a.* Carry a pocketbook or other container into the count room, unless it is transparent.

*b.* Remove their hands from or return them to a position on or above the count table unless the backs and palms of the hands are first held straight out and exposed to the view of other members of the count team and the closed circuit surveillance camera.

**12.15(4)** Requirements for conducting the count.

*a.* Immediately prior to the commencement of the count, the count team shall notify the person assigned to the surveillance room that the count is about to begin, after which the surveillance department shall make a video recording with the time and date inserted thereon of the entire counting process.

*b.* Prior to counting the contents of the containers, the doors to the count room shall be locked and no person shall be permitted to enter or leave the count room, except during an emergency or on scheduled breaks, until the entire counting, recording, and verification process is completed. During this time, a commission representative shall have unrestricted access.

*c.* When a container is placed on a count table or coin scale, the count team shall ensure that the table or machine number associated with a container is identified to the surveillance department.

*d.* A machine may be used to automatically count the contents of a container.

*e.* The contents of each container shall be emptied on the count table or coin scale and either manually counted separately on the count table or counted in an approved currency counting machine located in a conspicuous location on, near, or adjacent to the count table or coin scale. These procedures shall at all times be conducted in full view of the closed circuit surveillance cameras located in the count room.

*f.* Immediately after the contents of a container are emptied onto the count table or coin scale, the inside of the container shall be held up to the full view of a closed circuit surveillance camera and shall be shown to at least one other count team member to ensure all contents of the container have been removed and, if applicable, the container shall then be locked. By the end of the count process, empty containers shall be secured in a container cart or an area separate from uncounted containers.

*g.* If the original count is being performed by a machine that automatically counts and records the amounts of the contents of each individual container, an aggregate count may be permitted in substitution of a second container count.

*h.* For manually counted containers:

(1) The count team members shall place the contents of each container into separate stacks on the count table by denomination of currency and by type of form, record, or document, except that a machine may be used to automatically sort currency by denomination.

(2) Each denomination of currency shall be counted separately by one count team member who shall group currency of the same denomination on the count table in full view of a closed circuit surveillance camera. The currency shall then be counted by a second count team member who is unaware of the result of the original count. The second count team member, after completing this count, shall confirm the accuracy of the total, either orally or in writing, with that reached by the first count team member.

**12.15(5) Table games.**

*a.* As the contents of each container from a table game are counted, one count team member shall record the following information by game, table number, date, and time on a master game report or supporting documents:

- (1) The amount of each denomination of currency.
- (2) The amount of all denominations of currency.
- (3) The total amounts of currency.
- (4) The total amount of gaming chips.
- (5) The amount of the opener.
- (6) The amount of the closer.
- (7) The serial number and amount of each fill.
- (8) The amount of all fills.
- (9) The serial number and amount of each credit.
- (10) The amount of all credits.
- (11) The win or loss.

*b.* After the contents of each container are counted and recorded, one member of the count team shall record by game on the master game report the total amounts of currency, table inventory slips, fills, credits, and win or loss together with any other required information.

*c.* Notwithstanding the requirements of paragraphs 12.15(5) “*a*” and “*b*,” if the internal controls allow for the recording of fills, credits, and table inventory slips on the master game report or supporting documents prior to commencement of the count, a count team member shall compare for agreement the totals of the amounts recorded thereon to the fills, credits, and table inventory slips removed from the containers.

*d.* After preparation of the master game report, each count team member shall sign the report attesting to the accuracy of the information contained thereon.

*e.* Currency and gaming chips shall not be removed from the count room after commencement of the count until the total has been verified and accepted by a cashier. At the conclusion of the count, all currency and gaming chips removed from the containers shall be counted by a cashier in the presence of a count team member prior to having access to the information recorded on the master game report. The cashier shall attest to the accuracy of the amount received from the gaming tables by signature on the master game report, after which a count team member shall sign the master game report evidencing the fact that both the cashier and count team have agreed on the total counted. The verified funds shall then remain in the custody of the cashier.

*f.* After the master game report has been signed, the requests, slips, and table inventory slips removed from the containers shall be attached. The report, with attachments, shall then be transported directly to the accounting department or shall be maintained in locked storage until the master game report can be delivered to the accounting department. Upon meeting the signature requirements described in paragraph 12.15(5) “*e*,” the report shall not be available to any cashier’s cage personnel.

*g.* Unless the internal controls provide for the forwarding of the original requests and original slips from the cashier’s cage directly to the accounting department, the original requests and original slips recorded or to be recorded on the master game report shall be transported from the count room directly to the accounting department.

*h.* The originals and copies of the master game report, requests, slips, table inventory slips, and the test receipts from the currency counting equipment shall, on a gaming day basis in the accounting department, be:

(1) Compared for agreement with each other on a test basis if the originals are received from the count room by persons with no recording responsibilities and, if applicable, to copies remaining in the dispenser or stored data.

(2) Reviewed for the appropriate number and propriety of signatures on a test basis.

(3) Accounted for by series numbers, if applicable.

(4) Verified for proper calculation, summarization, and recording.

(5) Recorded.

(6) Maintained and controlled by the accounting department as a permanent accounting record.

**12.15(6) Slot machines.**

*a.* Currency shall not be removed from the count room after commencement of the count until the currency total has been verified and accepted by a cashier. At the conclusion of the count, all currency removed from the containers shall be counted by a cashier in the presence of a count team member prior to the recording of information on the slot drop sheet. The cashier shall attest to the accuracy of the amount of currency received from the slot machines by signature on the slot drop sheet, after which a count team member shall sign the slot drop sheet evidencing the fact that both the cashier and count team have agreed on the total amount of currency counted. The verified funds shall remain in the custody of the cashier.

*b.* The slot drop sheet and supporting documents shall be transported directly to the accounting department and shall not be available, except for signing, to any cashier's cage or slot personnel or shall be maintained in locked storage until they can be delivered to the accounting department.

*c.* The preparation of the slot drop sheet shall be completed by accounting employees as follows:

(1) Compare the amount of currency counted and the drop meter reading for agreement for each slot machine.

(2) Record the hopper fills for each slot machine.

(3) Record for each slot machine the payouts and compare for agreement the payouts to the manual jackpot meter reading recorded on the slot meter sheet.

(4) Calculate and record the win or loss for each slot machine.

(5) Explain and report for corrections of apparent meter malfunctions to the slot department all significant differences between meter readings and amounts recorded.

(6) Calculate statistics by slot machine.

*d.* The slot drop sheet, the slot meter sheet, payouts, and hopper fills shall be:

(1) Compared for agreement with each other and to copies or stored data on a test basis.

(2) Reviewed for the appropriate number and propriety of signatures on a test basis.

(3) Accounted for by series numbers, if applicable.

(4) Verified for proper calculation, summarization, and recording.

(5) Recorded.

(6) Maintained and controlled by accounting department employees.

[ARC 8029B, IAB 8/12/09, effective 9/16/09; ARC 9018B, IAB 8/25/10, effective 9/29/10]

**491—12.16(99F) Electronic wagering accounts.**

**12.16(1)** A facility may be allowed to offer electronic wagering accounts for patrons enrolled at that facility for use on premises at that facility. Prior to offering any electronic wagering accounts, the facility shall submit additional internal controls, approved by a commission representative in accordance with rule 491—12.3(99F), that include the following for operation of an account:

*a.* Limitation of one active account per individual player.

*b.* Details on how a player will be identified and the methods required to access funds in the account.

*c.* Process to easily and prominently impose limitations for wagering parameters including, but not limited to, deposits and wagers. Upon receipt, any self-imposed limitations must be employed

correctly and immediately as indicated to the player. No changes can be made reducing the severity of the self-imposed limitations for at least 24 hours. If the wagering account includes access to wagering account information, this process must include the capability to notify the player for self-imposed limitations.

*d.* Process to prohibit wagering by participants of the statewide self-exclusion program set forth in Iowa Code section 99F.4(22). The operator must ensure that newly enrolled participants are paid in full for their account balance within a reasonable time provided that the operator acknowledges that the funds have cleared.

**12.16(2)** The following requirements apply to the maintenance of funds associated with a player account:

*a.* A facility shall not have access to funds in a player's account, except to debit the account for a wager made by the player, to remit funds to the player at the player's request, or as otherwise authorized by the commission.

*b.* Methods of transfer or deposit into a player's account shall be limited to currency transactions with a casino cashier, or transfers from a participating gaming machine or designated kiosk, unless otherwise approved by the commission. Direct transfers utilizing accounts with outside entities are permitted, but transfers to a player's wagering account shall not be allowed while a patron is on the designated gaming floor, as approved pursuant to 491—subrule 5.4(17). Electronic wagering accounts shall not be funded with a credit card.

*c.* Positive player identification, including any personal identification number (PIN) entry or other approved secured methods, must be completed before the withdrawal of any moneys held by the facility.

*d.* It shall not be possible to transfer funds between two player accounts.

*e.* A facility shall provide a transaction log or account statement history at no cost to players upon request. Information provided shall include sufficient information to allow players to reconcile the statement or record against their own financial records and shall identify any device where a transaction occurred.

*f.* A facility shall not charge any fees for the registration, operation or maintenance of wagering accounts including, but not limited to, processing any deposits or withdrawals.

**12.16(3)** Abandoned player accounts under this rule are subject to Iowa Code chapter 556. Player accounts are considered abandoned if no activity by the account holder has occurred for three years. Player activity includes any deposit or withdrawal, including activity initiated by the player to make a wager on a participating gaming device.

[ARC 5422C, IAB 2/10/21, effective 3/17/21]

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CHAPTER 13  
SPORTS WAGERING

**491—13.1(99F) Definitions.** As used in these rules, unless the context otherwise requires, the following definitions apply:

*“Administrator”* means the administrator of the racing and gaming commission or the administrator’s designee.

*“Advance deposit sports wagering”* means a method of sports wagering in which an eligible individual may, in an account established with a licensee under Iowa Code section 99F.7A, deposit moneys into the account and use the account balance to pay for sports wagering. Prior to January 1, 2021, an account must be established by an eligible individual in person with a licensee.

*“Advance deposit sports wagering operator”* means an advance deposit sports wagering operator licensed by the commission who has entered into an agreement with a licensee under Iowa Code section 99F.7A to provide advance deposit sports wagering.

*“Authorized sporting event”* means a professional sporting event, collegiate sporting event, international sporting event, or professional motor race event. “Authorized sporting event” does not include a race as defined in Iowa Code section 99D.2, a fantasy sports contest as defined in Iowa Code section 99E.1, minor league sporting event, or any athletic event or competition of an interscholastic sport as defined in Iowa Code section 9A.102.

*“Collegiate sporting event”* means an athletic event or competition of an intercollegiate sport as defined in Iowa Code section 9A.102.

*“Commission”* means the racing and gaming commission created under Iowa Code section 99D.5.

*“Designated sports wagering area”* means an area, as designated by a licensee and approved by the commission, in which sports wagering is conducted.

*“Eligible individual”* means an individual who is at least 21 years of age or older who is located within this state.

*“Facility”* means an entity licensed by the commission to conduct pari-mutuel wagering, gaming or sports wagering operations in Iowa.

*“International sporting event”* means an international team or individual sporting event governed by an international sports federation or sports governing body, including but not limited to sporting events governed by the international olympic committee and the international federation of association football.

*“Licensee”* means any person licensed under Iowa Code section 99F.7 or 99F.7A.

*“Minor league sporting event”* means a sporting event conducted by a sports league which is not regarded as the premier league in the sport as determined by the commission.

*“Professional sporting event”* means an event, excluding a minor league sporting event, at which two or more persons participate in sports or athletic events and receive compensation in excess of actual expenses for their participation in such event.

*“Sports wagering”* means the acceptance of wagers on an authorized sporting event by any system of wagering as authorized by the commission. “Sports wagering” does not include placing a wager on the performance or nonperformance of any individual athlete participating in a single game or match of a collegiate sporting event in which a collegiate team from this state is a participant, or placing a wager on the performance of athletes in an individual international sporting event governed by the international olympic committee in which any participant in the international sporting event is under 18 years of age.

*“Sports wagering net receipts”* means the gross receipts less winnings paid to wagerers on sports wagering.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—13.2(99F) Conduct of all sports wagering.**

**13.2(1) Commission policy.** It is the policy of the commission to require that all industry participants conduct sports wagering in a manner suitable to protect the public health, safety, morals, good order, and general welfare of the state. Responsibility for selecting, implementing, and maintaining suitable methods of operation rests with the facility, vendor, and advance deposit sports wagering operator.

Willful or persistent use or toleration of methods of operation deemed unsuitable in the sole discretion of the commission will constitute grounds for disciplinary action, up to and including revocation.

**13.2(2) *Activities prohibited.*** A facility, vendor, or advance deposit sports wagering operator is expressly prohibited from the following activities:

*a.* Failing to conduct advertising and public relations activities in accordance with decency, dignity, good taste, and honesty.

*b.* Failing to comply with or make provision for compliance with all federal, state, and local laws and rules pertaining to the operation of a facility or advance deposit sports wagering operation including, but not limited to, payment of license fees, withholding payroll taxes, and violations of alcoholic beverage laws or regulations.

*c.* Permitting cheating, failing to discover cheating that should have been discovered with reasonable inquiry, or failing to take action to prevent cheating.

*d.* Failing to conduct sports wagering operations in accordance with proper standards of custom, decorum, and decency; or permitting any type of conduct that reflects negatively on the state or commission or acts as a detriment to the sports wagering industry.

*e.* Performing any type of sports wagering activity, at any time, that is contrary to the representation made to the commission, commission representatives, or the public.

*f.* Denying a commissioner or commission representative, upon proper and lawful demand, information, documents, or access to inspect any portion of the sports wagering operation.

**13.2(3) *Wagers.*** Wagers may only be made by persons 21 years of age or older and on activities authorized pursuant to Iowa Code chapter 99F which are approved by the commission.

**13.2(4) *Public notice.*** The public shall have access to the sports wagering rules, available wagers, odds or payouts, the payout period, and the source of the information used to determine the outcome of a sports wager. All licensees and advance deposit sports wagering operators shall require participants to follow the rules of play. The sports wagering rules shall be:

*a.* Displayed in the licensee's sports wagering area.

*b.* Posted on the internet site or mobile application used to conduct advance deposit sports wagering.

*c.* Included in any terms and conditions disclosure statements of the advance deposit sports wagering system.

**13.2(5) *Bond.*** A licensee shall post a bond or irrevocable letter of credit, at an amount determined by the commission, to the state of Iowa to guarantee that the licensee and any vendor or advance deposit sports wagering operator licensed in conjunction with the licensee faithfully makes the payments, keeps its books and records and makes reports, and conducts its gambling games and sports wagering in conformity with Iowa Code chapter 99F and the rules adopted by the commission.

**13.2(6) *Reserve.*** A reserve in the form of cash or cash equivalents segregated from operational funds, an irrevocable letter of credit, payment processor reserves and receivables, a bond, or a combination thereof, shall be maintained in the amount necessary to cover the outstanding sports wagering liability. An accounting of this reserve shall be made available for inspection to the commission upon request. The method of reserve shall be submitted to and approved by the administrator prior to implementation.

**13.2(7) *Internal controls.*** Licensees and advance deposit sports wagering operators shall submit a description of internal controls to the administrator. The submission shall be made at least 30 days before sports operations are to commence unless otherwise approved by the administrator. All internal controls must be approved by the administrator prior to commencement of sports operations. The operator shall submit to the administrator any changes to the internal controls previously approved at least 15 days before the changes are to become effective unless otherwise directed by the administrator. It shall be the affirmative responsibility and continuing duty of each licensee and advance deposit sports wagering operator and their employees to follow and comply with all internal controls. The submission shall include controls and reasonable methods that provide for the following:

*a.* To prohibit wagering by coaches, athletic trainers, officials, players, or other individuals who participate in an authorized sporting event in which wagers may be accepted.

b. To prohibit wagering by persons who are employed in a position with direct involvement with coaches, players, athletic trainers, officials, athletes or participants in an authorized sporting event in which wagers may be accepted.

c. To promptly report to the commission any criminal or disciplinary proceedings commenced against the licensee or its employees.

d. To promptly report to the commission any abnormal wagering activity or patterns that may indicate a concern about the integrity of an authorized sporting event or events, and any other conduct with the potential to corrupt a wagering outcome of an authorized sporting event for purposes of financial gain, including but not limited to match fixing, and suspicious or illegal wagering activities, including the use of funds derived from illegal activity, wagers to conceal or launder funds derived from illegal activity, use of agents to place wagers, or use of false identification. Integrity-monitoring procedures shall also provide for the sharing of information with other licensees, other governing authorities, and accredited sports governing entities by participating in an integrity-monitoring association or group or by another method as approved by the administrator.

e. To report within 72 hours, in writing, any incident where an employee or customer is detected violating a provision of Iowa Code chapter 99F, a commission rule or order, or internal controls. In addition to the written report, the licensee or advance deposit sports wagering operator shall provide immediate notification to the commission if an incident involves employee theft, criminal activity, Iowa Code chapter 99F violations or sports wagering receipts.

f. The segregation of incompatible functions so that no employee is in a position to perpetrate and conceal errors or irregularities in the normal course of the employee's duties.

g. User access controls for all sensitive and secure, physical and virtual, areas and systems within a sports wagering operation.

h. Treatment of problem gambling by:

(1) Identifying problem gamblers.

(2) Complying with the process established by the commission pursuant to Iowa Code section 99F.4(22) and 491—subrule 5.4(12).

(3) Cooperating with the Iowa gambling treatment program in creating and establishing controls.

(4) Making available to customers, patrons, and bettors a substantial number of the Iowa gambling treatment program advertisements and printed materials.

i. Setoff winnings of customers who have a valid lien established under Iowa Code chapter 99F.

**13.2(8) Revenue reporting.** Reports generated from the sports wagering system shall be made available as determined by the commission. The reporting system shall be capable of issuing reports by wagering day, wagering month, and wagering year. Wagering data shall not be purged unless approved by the commission. The reporting system shall provide for a mechanism to export the data for the purposes of data analysis and auditing or verification. The reporting system shall be able to provide, at a minimum, the following sports wagering information:

a. The date and time each event started and ended.

b. Total amount of wagers collected.

c. Total amount of winnings paid to players.

d. Total amount of wagers canceled, voided, and expired.

e. Commission or fees collected.

f. Total value of promotional play or free play used to purchase or execute a sports wager.

g. Event status.

h. Total amount held by the operator for the player accounts.

i. Total amount of wagers placed on future events.

j. Total amount of winnings owed but unpaid by the operator on winning wagers.

**13.2(9) Unclaimed winnings and abandoned accounts.** Unclaimed winnings and abandoned accounts are subject to the following requirements:

a. Abandoned player accounts under this rule are subject to Iowa Code chapter 556.

b. Player accounts are considered abandoned if no activity by the account holder has occurred for three years. Player activity includes making a wager, making an account deposit, or withdrawing funds.

c. No licensee or advance deposit sports wagering operator shall charge an administration fee or maintenance fee for any inactive player account derived from state of Iowa residents at any time for any reason.

**13.2(10) Annual audit.** If a vendor is conducting sports wagering for a casino licensee, an audit of the sports wagering operations for the vendor or parent company of the vendor shall be conducted by certified public accountants authorized to practice in the state of Iowa, and the audit shall be provided to the commission within 90 days of the vendor's fiscal year and meet the following conditions:

a. Inclusion of an internal control letter, audited balance sheet, and audited profit-and-loss statement including a breakdown of expenditures and subsidiaries of sports wagering activities.

b. Inclusion of a supplement schedule indicating financial activities on a calendar-year basis if the vendor's fiscal year does not correspond to the calendar year.

c. Inclusion of a supplement schedule for all Iowa locations in which the vendor operates.

d. Report of any material errors, irregularities that may be discovered during the audit, or notice of any audit adjustments.

e. Availability, upon request, of an engagement letter for the audit between the vendor or parent company of the vendor and the auditing firm.

**13.2(11) Revenue reports.** Licensees and advance deposit sports wagering operators shall provide additional reports, as determined necessary by the administrator, that detail the revenue submission required by 491—paragraph 5.4(10)“d.” Reports shall be provided to the commission in a format approved by the administrator. The administrator shall provide written notice to any licensee if additional reports are determined necessary. In addition, the administrator shall provide adequate time to any licensee if a report needs to be created to satisfy this requirement.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; see Suspension note at end of chapter; ARC 5016C, IAB 4/8/20, effective 5/13/20; see Delay note at end of chapter; ARC 5422C, IAB 2/10/21, effective 3/17/21]

#### **491—13.3(99F) Approval of sports wagers.**

**13.3(1) Approval.** Prior to offering a sports wager, a facility or advance deposit sports wagering operator shall request that the administrator investigate and approve the sports wager for compliance with commission rules and any other standards as required by the commission. The administrator may require the facility or advance deposit sports wagering operator, at the facility's or operator's own expense, to provide additional information as deemed necessary to make a determination. Prior to approval, the administrator may require a trial period of any sports wager offering. Once a sports wager is approved by the administrator, unless it is subsequently disapproved for any reason deemed appropriate by the administrator, the sports wager is available for all operators under the conditions approved and subject to subrule 13.3(2).

**13.3(2) Sports wager submissions.** Prior to conducting a sports wager approved pursuant to subrule 13.3(1), a licensee or advance deposit sports wagering operator shall submit proposals for the wager, including but not limited to wagering rules, payout information, source of the information used to determine the outcome of the sports wager, and any restrictive features of the wager. The sports wager submission, or requests for modification to an approved wager, shall be submitted in writing and approved by the administrator prior to implementation.

**13.3(3) Sports promotional contests, tournaments, or promotional activities.** Sports promotional contests, tournaments, or promotional activities may be permitted by the licensee, vendor, or advance deposit sports wagering operator providing the following:

a. Rules shall be made available to participants for review prior to registering. Rules shall include, at a minimum: all conditions registered players must meet to qualify to enter or advance through the event, available prizes or awards, fees, and distribution of prizes or awards based on specific outcomes.

b. Rules are followed. Changes to rules shall not be made after participants have registered.

c. Results shall be made available for the registered players to review at the same location at which or in the same manner in which players registered. Results shall include, at a minimum: name of the event, date of the event, total number of entries, amount of entry fees, total prize pool, and amount paid for each winning category.

*d.* Fees collected, less cash prizes paid, are subject to the wagering taxes pursuant to Iowa Code section 99F.11(4). In determining sports wagering net receipts, to the extent that cash prizes paid out exceed fees collected, the licensee or advance deposit sports wagering operator shall be deemed to have paid the fees for the participants.

*e.* Rules include terms and conditions. All emails or digital advertisements promoting contests, tournaments, and promotional activities shall include a link or other easily obtainable source that includes rules or terms and conditions.

*f.* There is compliance with all other federal, state, and local laws and rules outside of the commission's jurisdiction.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20; ARC 5422C, IAB 2/10/21, effective 3/17/21]

**491—13.4(99F) Designated sports wagering area.** A floor plan identifying the designated sports wagering area, including the location of any wagering kiosks, shall be filed with the administrator for review and approval. Modification to a previously approved plan must be submitted for approval at least ten days prior to implementation. A sign shall denote that the area is not accessible to persons under the age of 21. Exceptions to this rule must be approved in writing by the administrator. The sports wagering area is subject to compliance with 491—subrule 5.4(7).

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—13.5(99F) Advance deposit sports wagering.**

**13.5(1) Authorization to conduct advance deposit sports wagering.** A licensee or advance deposit sports wagering operator shall receive specific authorization from the commission to conduct advance deposit sports wagering prior to conducting advance deposit sports wagering. The granting of an advance deposit sports wagering license or approval of any agreements between a licensee and an advance deposit sports wagering operator to conduct advance deposit sports wagering does not constitute authorization. Any entity authorized to conduct advance deposit sports wagering is expected to comply with all requirements of this chapter, except for rule 491—13.4(99F), and all other applicable federal, state, local, and commission requirements.

**13.5(2) Account registration.** A person must have an established account in order to place advance deposit sports wagers. The process for establishing an account is subject to the administrator's approval. Prior to January 1, 2021, an account shall be established at the facility as required by Iowa Code section 99F.9(4). On or after January 1, 2021, an account may be established through on-site registration under procedures previously approved by the administrator, or through remote registration. To establish an account, an application for an account shall be signed or otherwise authorized in a manner approved by the administrator and shall include the applicant's full legal name, principal residential address, date of birth, and any other information required by the administrator. The account registration process shall also include:

*a.* Age verification to prevent persons under the legal age for sports wagering from establishing an account.

*b.* Player verification of legal name, physical address, and age to correctly identify account holders.

*c.* Verification that the player is not on the statewide self-exclusion list set forth in Iowa Code section 99F.4(22) prior to establishing an account.

*d.* Availability and acceptance of a set of terms and conditions that is also readily accessible to the player before and after registration and noticed when updated. Notices shall include, at a minimum, the following:

(1) Explanation of rules in which any unrecoverable malfunctions of hardware/software are addressed including, but not limited to, if the unrecoverable malfunction, wagering event cancellation, or other catastrophic malfunction results in the voiding of any wagers.

(2) Procedures to deal with interruptions caused by the suspension of data flow from the network server during an event.

(3) Specifications advising players to keep their account credentials secure.

- (4) Statement that no underage individuals are permitted to participate in wagering.
- (5) Explanation of conditions under which an account is declared inactive and actions undertaken on the account once this declaration is made.

*e.* Availability and acceptance of a privacy policy that is also readily accessible to the player before and after registration and noticed when updated and that includes, at a minimum, the following:

(1) Statement of information that is collected, the purpose for information collection, and the conditions under which information may be disclosed.

(2) Statement that any information obtained in respect to player registration or account establishment must be done in compliance with the privacy policy.

(3) Requirement that any information about player accounts which is not subject to disclosure pursuant to the privacy policy must be kept confidential, except where the release of that information is required by law.

(4) Requirement that all player information must be securely erased from hard disks, magnetic tapes, solid state memory, and other devices before the device is properly disposed of by the licensee. If erasure is not possible, the storage device must be destroyed.

*f.* If an advance deposit sports wagering operator has an agreement with more than one licensee, the advance deposit sports wagering operator shall submit an agreement to the administrator that indicates the manner in which customer net receipts shall be assigned with its licensee partners. The agreement shall include all partnering licensees and their respective qualified sponsoring organizations, and the net receipts shall be allocated using one of the following methods:

(1) Make available an option for new remotely registered customers to select the licensee at which net receipts are assigned.

(2) Allocate new remotely registered customer net receipts to the licensee which is located nearest to the customer's principal residential address.

(3) Distribute all customer receipts evenly between all licensees for which an agreement exists.

(4) An alternative allocation agreement that complies with local, state and federal law.

The agreement shall be made available for public inspection.

**13.5(3) Operation of an account.** The advance deposit sports wagering operator or a licensee shall submit controls, approved by the commission, that include the following for operating an account:

*a.* Specific procedures and technology partners to fulfill the requirements set forth in subrule 13.5(2).

*b.* Location detection procedures to reasonably detect and dynamically monitor the location of a player attempting to place any wager. A player outside the permitted boundary shall be rejected, and the player shall be notified. The confidence radius shall be entirely located within the permitted boundary.

*c.* Specific controls set forth in subrule 13.2(7).

*d.* Limitation of one active account, per individually branded website, at a time unless otherwise authorized by the commission.

*e.* Authentication for log in through a username and password or other secure alternative means as authorized by the commission. Processes for retrieving lost usernames and passwords shall be available, secure, and clearly disclosed to the player. Players shall be allowed to change their passwords.

*f.* Immediate notification to the player when changes are made to any account used for financial transactions or to registration information or when financial transactions are made unless other notification preferences are established by the player.

*g.* Process to immediately notify a player and lock an account in the event that suspicious activity is detected. A multifactor authentication process must be employed for the account to be unlocked.

*h.* Process to easily and prominently impose limitations or notifications for wagering parameters including, but not limited to, deposits and wagers. Upon receipt, any self-imposed limitations must be employed correctly and immediately as indicated to the player. No changes can be made reducing the severity of the self-imposed limitations for at least 24 hours.

*i.* Process to easily and prominently self-exclude from wagering for a specified period of time or indefinitely and easily and obviously direct participants, via a link, to exclude themselves pursuant to Iowa Code section 99F.4(22). Upon receipt, any self-exclusion limitations must be employed correctly

and immediately as indicated to the player. No changes can be made to reduce the severity of the self-exclusion limitations for at least 24 hours. In the event of indefinite self-exclusion, the advance deposit sports wagering operator or licensee must ensure that the players are paid in full for their account balance within a reasonable time provided that the advance deposit sports wagering operator or licensee acknowledges that the funds have cleared. This control does not supersede the requirements set forth in Iowa Code section 99F.4(22).

*j.* Process to review and deactivate accounts of newly enrolled participants of the statewide self-exclusion program set forth in Iowa Code section 99F.4(22). The operator must ensure that players are paid in full for their account balance within a reasonable time provided that the operator acknowledges that the funds have cleared.

*k.* Provide for an easy and obvious method for a player to make a complaint and to enable the player to notify the commission if such complaint has not been or cannot be addressed by the advance deposit sports wagering operator or licensee.

**13.5(4) *Account funds.*** The following requirements apply to the maintenance of funds associated with a player account:

*a.* Positive player identification, including any personal identification number (PIN) entry or other approved secure methods, must be completed before the withdrawal of any moneys held by the advance deposit sports wagering operator or licensee can be made.

*b.* Payments from an account are to be paid directly to an account with a financial institution in the name of the player or made payable to the player and forwarded to the player's address or through another method that is not prohibited by state or federal law.

*c.* An advance deposit sports wagering operator or licensee must have in place security or authorization procedures to ensure that only authorized adjustments can be made to player accounts and that changes are auditable.

*d.* It shall not be possible to transfer funds between two player accounts.

*e.* An advance deposit sports wagering operator or licensee shall provide a transaction log or account statement history at no cost to players upon request. Information provided shall include sufficient information to allow players to reconcile the statement or log against their own financial records.

*f.* Requests for withdrawals shall not be unreasonably withheld and shall be completed in a timely manner.

*g.* An advance deposit sports wagering operator or licensee shall provide a fee-free method for players to deposit or withdraw funds from player accounts.

*h.* An advance deposit sports wagering operator or licensee shall segregate player account funds from operational funds.

**13.5(5) *Annual audit.*** An audit of the advance deposit sports wagering operations for the advance deposit sports wagering operator or licensee or parent company of the advance deposit sports wagering operator or licensee shall be conducted by certified public accountants authorized to practice in the state of Iowa and provided to the commission within 90 days of the licensee's fiscal year and meet the following conditions:

*a.* Inclusion of an internal control letter, audited balance sheet, and audited profit-and-loss statement including a breakdown of expenditures and subsidiaries of advance deposit sports wagering activities.

*b.* Inclusion of a supplement schedule indicating financial activities on a calendar-year basis if the advance deposit sports wagering operator's or licensee's fiscal year does not correspond to the calendar year.

*c.* Report of any material errors, irregularities that may be discovered during the audit, or notice of any audit adjustments.

*d.* Availability, upon request, of an engagement letter for the audit between the advance deposit sports wagering operator or licensee or parent company of the advance deposit sports wagering operator or licensee and the auditing firm.

*e.* Inclusion of a supplemental schedule for Iowa operations. A supplemental schedule shall include a breakdown of advance deposit sports wagering activities by each Iowa casino in which there

is an agreement. The supplemental schedule provided to satisfy this requirement may be unaudited; however, the top financial officer of the company shall provide a statement attesting to the accuracy of the information provided to the commission.

**13.5(6) *Wagers.*** An advance deposit sports wagering operator shall display a player's wagers in a readily accessible manner.

**13.5(7) *Expiration or termination of an Iowa Code section 99F.7A operating agreement.*** In the event an advance deposit sports wagering operating agreement between a licensee under Iowa Code section 99F.7A and another entity expires, terminates, or is no longer valid, notice of termination must be given to the commission and all customers affiliated with the licensee. A customer shall be given an opportunity to close an account. If the advance deposit sports wagering operator has an operating agreement with other licensees in the state of Iowa, the customer shall have the option to select another partner licensee to which their net receipts shall be assigned, or the customer's net receipts shall be assigned to any remaining partner licensees in accordance with an agreement submitted to the administrator pursuant to paragraph 13.5(2) "f."

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20; ARC 5422C, IAB 2/10/21, effective 3/17/21]

#### **491—13.6(99F) Testing.**

**13.6(1) *Initial testing.*** All equipment and systems integral to the conduct of sports wagering and advance deposit sports wagering shall be tested and certified for compliance with commission rules and the standards required by a commission-designated independent testing laboratory. Certification and commission approval must be received prior to the use of any equipment or system to conduct sports wagering. The commission may designate more than one independent testing laboratory.

**13.6(2) *Change control.*** The licensees and advance deposit sports wagering operators shall submit change control processes that detail evaluation procedures for all updates and changes to equipment and systems to the administrator for approval. These processes shall include details for identifying criticality of updates and determining of submission of updates to an independent testing laboratory for review and certification.

#### **13.6(3) *Annual testing.***

*a.* A system integrity and security risk assessment shall be performed annually on the advance deposit sports wagering system.

(1) The testing organization must be independent of the licensee and shall be qualified by the administrator.

(2) The system integrity and security risk assessment shall be conducted no later than 90 days after the start of the licensee's fiscal year.

(3) Results from the risk assessment shall be submitted to the administrator no later than 30 days after the assessment is conducted.

*b.* At the discretion of the administrator, additional assessments or specific testing criteria may be required.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

#### **491—13.7(99F) Licensing.**

**13.7(1) *Application and payment of fee.*** The commission shall, upon payment of an initial license fee of \$45,000 and submission of an application consistent with the requirements of Iowa Code section 99F.6, issue a license to conduct sports wagering to a facility.

**13.7(2) *Application procedure for a facility.*** Application for a license for a facility to conduct sports wagering shall be made to the commission. In addition to the application, the following must be completed and presented when the application is filed:

*a.* Name of the entity to be licensed by the commission to conduct sports wagering operations in Iowa.

*b.* Disclosure of agreements with entities to manage or operate sports wagering with or on behalf of the facility.

c. Disclosure of operating agreements for up to two, or three if authorized by the commission, individually branded internet sites to conduct advance deposit wagering for the facility.

d. Compliance with Iowa Code section 99F.6(4)“a”(2) and (3) requirements for qualified sponsoring organizations or horse racing purses.

e. A bond or irrevocable letter of credit on behalf of the facility in an amount to be determined by the commission.

f. A bank check, cashier’s check, or wire transfer made payable to Iowa Racing and Gaming Commission for \$45,000 for an initial license or \$10,000 for a renewal license.

**13.7(3)** *Application procedure for an advance deposit sports wagering operator.* Application for a license for an advance deposit sports wagering operator with an agreement with a facility shall be made to the commission for approval by the administrator. In addition to the application, the following must be completed and presented when the application is filed:

a. Disclosure of ownership interest, directors, or officers of applicant.

(1) An applicant or licensee shall notify the administrator of the identity of each director, corporate officer, owner, partner, joint venture participant, trustee, or any other person who has any beneficial interest of 5 percent or more, direct or indirect, in the business entity. For any of the above, as required by the administrator, the applicant or licensee shall submit background information on forms supplied by the division of criminal investigation and any other information the administrator may require.

For purposes of this rule, the term “beneficial interest” includes all direct and indirect forms of ownership or control, voting power, or investment power held through any contract, lien, lease, partnership, stockholding, syndication, joint venture, understanding, relationship (including family relationship), present or reversionary right, title or interest, or otherwise.

(2) For ownership interests of less than 5 percent, the administrator may request a list of these interests. The list shall include names, percentages owned, addresses, social security numbers, and dates of birth. The administrator may request the same information required of those individuals in subparagraph 13.7(3)“a”(1) above.

b. Investigative fees.

(1) Advance payment. The department of public safety may request payment of the investigative fee in advance as a condition to beginning investigation.

(2) Payment required. The administrator may withhold final action with respect to any application until all investigative fees have been paid in full.

c. A copy of each of the following:

(1) List of employees of the aforementioned who may have contact with persons within the state of Iowa.

(2) Agreement with facility to operate or manage the advance deposit sports wagering operation.

d. Any and all changes in the applicant’s legal structure, directors, officers, or the respective ownership interests must be promptly filed with the administrator.

e. The administrator may deny, suspend, or revoke the license of an applicant or licensee in which a director, corporate officer, or holder of a beneficial interest includes or involves any person or entity which would be, or is, ineligible in any respect, such as through want of character, moral fitness, financial responsibility, or professional qualifications, or due to failure to meet other criteria employed by the administrator, to participate in gaming regardless of the percentage of ownership interest involved. The administrator may order the ineligible person or entity to terminate all relationships with the licensee or applicant, including divestiture of any ownership interest or beneficial interest at acquisition cost.

f. Disclosure of the full nature and extent of all beneficial interests may be requested by the administrator and shall include the names of individuals and entities, the nature of their relationships, and the exact nature of their beneficial interest.

g. Public disclosure is made for the benefit of the public, and documents pertaining to the ownership filed with the administrator shall be available for public inspection in accordance with 491—Chapter 3.

**13.7(4)** *Supplementary information.* Each applicant shall promptly furnish the administrator with all additional information pertaining to the application or the applicant which the administrator may require.

Failure to supply the requested information within five days after the request has been received by the applicant shall constitute grounds for delaying consideration of the application.

**13.7(5) Temporary license certificates.**

*a.* A temporary license certificate may be issued at the discretion of the administrator.

*b.* Any temporary license certificate issued at the discretion of the administrator shall be valid for a maximum of 120 calendar days from the date of issue. Failure to obtain a permanent license within the designated time may result in revocation of license eligibility, fine, or suspension.

**13.7(6) Withdrawal of application.** A written notice of withdrawal of application may be filed by an applicant at any time prior to final action. No application shall be permitted to be withdrawn unless the administrator determines the withdrawal to be in the public interest. No fee or other payment relating to any application shall become refundable by reason of withdrawal of the application.

**13.7(7) Record keeping.**

*a.* Record storage required. Licensees and advance deposit sports wagering operators shall maintain adequate records of business operations, which shall be made available to the administrator upon request. These records shall include:

(1) All correspondence with the administrator and other governmental agencies on the local, state, and federal level.

(2) All correspondence between the licensee and advance deposit sports wagering operators and any of their customers who are applicants or licensees under Iowa Code chapter 99F.

(3) A personnel file on each employee of the licensee and advance deposit sports wagering operator, including sales representatives.

(4) Financial records of all transactions with facilities and all other licensees and advance deposit sports wagering operators under these rules.

*b.* Record retention. Records other than those listed in subrule 13.2(8) shall be retained as required by 491—subrule 5.4(14).

**13.7(8) Violation of laws or regulations.** Violation of any provision of any laws of the state or of the United States of America or of any rules of the commission may constitute an unsuitable method of operation, subjecting the licensee to limiting, conditioning, restricting, revoking or suspending the license, or fining the licensee or advance deposit sports wagering operator, or any combination of the above. The commission has the discretion to suspend mobile gaming operations of its licensees by written order if necessary.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20; ARC 5422C, IAB 2/10/21, effective 3/17/21]

These rules are intended to implement Iowa Code chapters 99D and 99F.

[Filed Emergency ARC 4618C, IAB 8/28/19, effective 7/31/19]<sup>1</sup>

[Filed ARC 5016C (Amended Notice ARC 4807C, IAB 12/18/19; Notice ARC 4617C, IAB 8/28/19), IAB 4/8/20, effective 5/13/20]<sup>2</sup>

[Filed ARC 5422C (Notice ARC 5269C, IAB 11/18/20), IAB 2/10/21, effective 3/17/21]

<sup>1</sup> Applicability of paragraph 13.2(7)“i” suspended until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held August 12, 2019. Suspension superseded by adoption of paragraph 13.2(7)“i” in ARC 5016C, effective 5/13/20.

<sup>2</sup> Applicability of paragraph 13.2(7)“i” delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held May 8, 2020.

CHAPTER 14  
FANTASY SPORTS CONTESTS

**491—14.1(99E) Definitions.** As used in these rules, unless the context otherwise requires, the following definitions apply:

*“Administrator”* means the administrator of the racing and gaming commission or the administrator’s designee.

*“Applicant”* means an internet fantasy sports contest service provider applying for a license to conduct internet fantasy sports contests under this chapter.

*“Commission”* means the state racing and gaming commission created under Iowa Code section 99D.5.

*“Entry fee”* means cash or cash equivalent that is required to be paid by an internet fantasy sports contest player to an internet fantasy sports contest service provider in order to participate in a fantasy sports contest.

*“Fantasy sports contest”* or *“contest”* means a fantasy or simulated game or contest in which:

1. The fantasy sports contest operator is not a participant in the game or contest;
2. The value of all prizes and awards offered to winning participants are established and made known to the participants in advance of the contest;
3. All winning outcomes reflect the relative knowledge and skill of the participants;
4. The outcome shall be determined by accumulated statistical results of the performance of individuals, including athletes in the case of sporting events; and
5. No winning outcome is solely based on the score, point spread, or any performance or performances of any single actual team or solely on any single performance of an individual athlete or player in any single actual event. However, until May 1, 2020, “fantasy sports contest” does not include any fantasy or simulated game or contest in which any winning outcomes are based on statistical results from a collegiate sporting event as defined in Iowa Code section 99F.1.

*“Fantasy sports contest service provider”* means a person, including a licensee under Iowa Code chapter 99D, 99E or 99F, who conducts an internet fantasy sports contest as authorized by this chapter.

*“Highly experienced player”* means a person who has entered more than 1,000 contests conducted by a single fantasy sports contest service provider or has won more than three fantasy sports contest prizes of \$1,000 or more from a single fantasy sports contest service provider. A fantasy sports contest provider may declare other players a “highly experienced player” so long as the provider’s criteria for declaration would include players previously declared a “highly experienced player” by the provider.

*“Internal controls”* means the fantasy sports contest service provider’s system of internal controls.

*“Licensee”* means any person licensed under Iowa Code section 99E.5 to conduct internet fantasy sports contests.

*“Location percentage”* means, for each internet fantasy sports contest, the percentage, rounded to the nearest tenth of a percent, equal to the total charges and fees collected from all internet fantasy sports contest players located in this state divided by the total charges and fees collected from all participants in the internet fantasy sports contest.

*“Net revenue”* means an amount equal to the total entry and administrative fees collected from all participants entering fantasy sports contests less winnings paid to participants in the contest, multiplied by the location percentage.

*“Player”* or *“customer”* means a person who is at least 21 years of age and participates in an internet fantasy sports contest operated by an internet fantasy sports contest service provider.

*“Prize”* means anything of value, including cash or a cash equivalent, contest credits, merchandise or entry to another contest in which a prize may be awarded.

*“Script”* means a list of commands that a fantasy sports-related computer program can execute and is created by fantasy sports players, or by third parties for the use of all players, to automate processes on a fantasy sports contest internet platform.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—14.2(99E) Application for fantasy sports contest service provider license and licensing.** A fantasy sports contest service provider must be licensed by the commission to offer an internet fantasy sports contest under Iowa Code chapter 99E. Any individuals who are required to be occupationally licensed by the commission shall comply with the license requirements of Iowa Code section 99E.5 and rules 491—6.2(99D,99E,99F,252J) to 491—6.13(99D,99F,272D). Occupational licensees are also subject to 491—Chapter 4.

**14.2(1) Licensing standards.** Standards which shall be considered when determining the qualifications of an applicant shall include, but are not limited to, financial stability; business ability and experience; good character and reputation of the applicant as well as all directors, officers, partners, and employees and integrity of financial backers. For the purposes of this rule, the term “applicant” includes each member of the board of directors or other governing body of an applicant.

*a.* The commission shall not grant a license to an applicant if there is substantial evidence that any of the following apply:

(1) A license issued to the applicant to conduct internet fantasy sports contests in another jurisdiction has been revoked, or a request for a license to conduct internet fantasy sports contests in another jurisdiction has been denied, by an entity licensing persons to conduct such contests in that jurisdiction.

(2) The applicant has not demonstrated financial responsibility sufficient to adequately meet the requirements of the enterprise proposed.

(3) The applicant does not adequately disclose the true owners of the enterprise proposed.

(4) The applicant has knowingly made a false statement of a material fact to the commission.

(5) The applicant has failed to meet a monetary obligation in connection with conducting an internet fantasy sports contest.

(6) The applicant is not of good repute and moral character or the applicant has pled guilty to, or has been convicted of, a felony.

(7) Any member of the board of directors or governing body of the applicant is not 21 years of age or older.

*b.* A person who knowingly makes a false statement on the application is guilty of an aggravated misdemeanor.

**14.2(2) Application procedure.** Application for an internet fantasy sports contest service provider license shall be made to the commission on the form prescribed and published by the commission. In addition to the application, the following must be completed and presented when the application is filed:

*a.* Disclosure of ownership interest, directors, or officers of applicant.

*b.* The identity and date of birth of each member of the board of directors or other governing body of the applicant.

*c.* The identity of each director, corporate officer, owner, partner, joint venture participant, trustee, or any other person who has any beneficial interest of 5 percent or more, direct or indirect, in the business entity. For any of the above, as required by the administrator, the applicant or licensee shall submit background information on forms supplied by the division of criminal investigation and any other information the administrator may require. For purposes of this rule, the term “beneficial interest” includes all direct and indirect forms of ownership or control, voting power, or investment power held through any contract, lien, lease, partnership, stockholding, syndication, joint venture, understanding, relationship (including family relationship), present or reversionary right, title or interest, or otherwise.

*d.* For ownership interests of less than 5 percent, the administrator may request a list of these interests. At a minimum, the list shall include names, percentages owned, addresses, social security numbers, and dates of birth. The administrator may request the same information required of those individuals in subrule 14.2(1).

*e.* A list of employees of the aforementioned who may be conducting business directly or indirectly on behalf of the applicant in the state of Iowa.

*f.* A bond or irrevocable letter of credit on behalf of the applicant or other satisfactory evidence, as determined by the commission, of a safe and reliable means of fulfilling the applicant’s obligations to customers and the state of Iowa in an amount determined by the commission.

**14.2(3) Investigative fee.**

a. Advance payment. The department of public safety may request payment of the investigative fee in advance as a condition to beginning the investigation.

b. Payment required. The administrator may withhold final action with respect to any application until all investigative fees have been paid in full.

**14.2(4) Application fee.** A bank or cashier's check shall be made payable to Iowa Racing and Gaming Commission for \$5,000.

**14.2(5) Reporting of changes.** Any and all changes in the applicant's legal structure, directors, officers, or the respective ownership interests must be promptly filed with the administrator.

**14.2(6) Ineligibility.** The administrator may deny, suspend, or revoke the license of an applicant or licensee in which a director, corporate officer, or holder of a beneficial interest includes or involves any person or entity which would be, or is, ineligible in any respect, such as through want of character, moral fitness, financial responsibility, or professional qualifications, or due to failure to meet other criteria employed by the administrator, to participate in gaming regardless of the percentage of ownership interest involved. The administrator may order the ineligible person or entity to terminate all relationships with the licensee or applicant, including divestiture of any ownership interest or beneficial interest at acquisition cost.

**14.2(7) Disclosure.** Disclosure of the full nature and extent of all beneficial interests may be requested by the administrator and shall include the names of individuals and entities, the nature of their relationships, and the exact nature of their beneficial interest.

**14.2(8) Public disclosure.** Disclosure is made for the benefit of the public, and all documents pertaining to the ownership filed with the administrator shall be available for public inspection.

**14.2(9) Supplementary information.** Each applicant shall promptly furnish the administrator with all additional information pertaining to the application or the applicant which the administrator may require. Failure to supply the requested information within five days after the request has been received by the applicant shall constitute grounds for delaying consideration of the application.

**14.2(10) Requirements placed upon applicants and licensees.** For purposes of this chapter, the requirements placed upon an applicant shall become a requirement to the licensee once a license has been granted. Every license is granted upon the condition that the license holder shall accept, observe, and enforce the rules and regulations of the commission. It is the affirmative responsibility and continuing duty of each officer, director, and employee of said license holder to comply with the requirements of the application and conditions of license and to observe and enforce the rules. The holding of a license is a privilege. The burden of proving qualifications for the privilege to receive any license is on the licensee at all times. A licensee must accept all risks of adverse public notice or public opinion, embarrassment, criticism, or financial loss that may result from action with respect to a license. Licensees further covenant and agree to hold harmless and indemnify the Iowa racing and gaming commission from any claim arising from any action of the commission in connection with that license.  
[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—14.3(99E) Temporary license certificates.**

**14.3(1)** A temporary license certificate may be issued at the discretion of the administrator.

**14.3(2)** Any temporary license certificate issued at the discretion of the administrator shall be valid for a maximum of 120 calendar days from the date of issue. Failure to obtain a permanent license within the designated time may result in revocation of license eligibility, fine, or suspension.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—14.4(99E) Withdrawal of application.** A written notice of withdrawal of application may be filed by an applicant at any time prior to final action. No application shall be permitted to be withdrawn unless the administrator determines the withdrawal to be in the public interest. No fee or other payment relating to any application shall become refundable by reason of withdrawal of the application.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—14.5(99E) Fees.**

**14.5(1) Initial license.** Once the commission is satisfied that the requirements of this chapter have been met, an applicant will be granted an initial license for up to three years.

**14.5(2) Annual license fee.** After the initial licensing period, a licensee shall pay an annual fee of \$1,000 for licensees with a yearly adjusted gross revenue under \$150,000 or \$5,000 for licensees with a yearly adjusted gross revenue of \$150,000 or greater. The administrator shall set the time period for determining a licensee's adjusted gross revenue. Licenses must be renewed annually in a manner established by the commission.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

#### **491—14.6(99E) Taxes.**

**14.6(1)** The licensee shall pay a tax rate pursuant to Iowa Code section 99E.6 on adjusted revenue from fantasy sports contests. "Adjusted revenue" means the amount equal to the total charges and fees collected from all participants entering the fantasy sports contest less winnings paid to participants in the contest, multiplied by the location percentage defined in Iowa Code section 99E.1. Charges and fees returned to participants due to a participant withdrawing the participant's entry from a fantasy sports contest shall not be considered when calculating the adjusted revenue. Contests resulting in negative adjusted revenue shall be considered promotional in nature and cannot be used to offset taxes owed pursuant to Iowa Code section 99E.6.

**14.6(2)** Voided and canceled transactions are not considered receipts for the purpose of this calculation.

**14.6(3)** Any offering used to directly participate in a contest shall be considered receipts for the purpose of this calculation.

**14.6(4)** Any other fee collected to participate in a fantasy sports contest shall be subject to the wagering tax pursuant to Iowa Code section 99E.6.

**14.6(5)** All moneys collected for and owed to the state of Iowa under Iowa Code chapter 99E for the payment of fantasy sports contests shall be accounted for and itemized on a monthly basis, in a format approved by the commission, by noon on Wednesday following a gaming week's end as defined by 491—subparagraph 5.4(10)"b"(1) in which the completed gaming week includes the last day of the month. All fantasy sports contest fees owed shall be received in the treasurer's office by 11 a.m. on the Thursday after accounting and itemization is due in the commission office.

**14.6(6)** Fantasy sports operators shall provide additional reports, as determined necessary by the administrator, that detail the taxes collected in accordance with this rule. Reports shall be provided to the commission in a format approved by the administrator. The administrator shall provide written notice to any licensee if additional reports are determined necessary. In addition, the administrator shall provide adequate time to any licensee if a report needs to be created to satisfy this requirement.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20; ARC 5422C, IAB 2/10/21, effective 3/17/21]

**491—14.7(99E) Account registration.** A person must have an established account in order to participate in fantasy sports contests. To establish an account, an application for an account shall be authorized in a manner approved by the administrator and shall include the applicant's full legal name, principal residential address, date of birth and any other information required by the commission. The account registration process shall also include:

**14.7(1)** Age verification to prevent persons under the legal age from participating in fantasy sports contests and establishing an account.

**14.7(2)** Customer verification of legal name, physical address and age to correctly identify account holders.

**14.7(3)** Verification that the customer is not on the statewide self-exclusion list set forth in Iowa Code section 99F.4(22) prior to establishing an account.

**14.7(4)** Availability and acceptance of a set of terms and conditions that are also readily accessible to the customer before and after registration and noticed when updated. Notices shall include, at a minimum, the following:

a. Explanation of rules in which any unrecoverable malfunctions of hardware/software are addressed including, but not limited to, if the unrecoverable malfunction, fantasy sports event cancellation, or any other catastrophic malfunction results in the voiding of any contests.

b. Procedures to deal with interruptions caused by the suspension of data flow from the network server during a contest.

c. Specifications advising customers to keep their account credentials secure.

d. Statement that no underage individuals are permitted to participate in contests.

**14.7(5)** Availability and acceptance of a privacy policy that is also readily accessible to the customer before and after registration and noticed when updated that includes, at a minimum, the following:

a. Statement of information that is collected, the purpose for information collection and the conditions under which information may be disclosed.

b. Statement that any information obtained in respect to customer registration or account establishment must be done in compliance with the privacy policy.

c. Requirement that any information about customer accounts which is not subject to disclosure pursuant to the privacy policy must be kept confidential, except where the release of that information is required by law.

d. Requirement that all customer information must be securely erased from hard disks, magnetic tapes, solid state memory and other devices before the device is properly disposed of by the licensee. If erasure is not possible, the storage device must be destroyed.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—14.8(99E) Fantasy sports contest service provider requirements.**

**14.8(1)** *Internal controls.* Licensees shall submit a description of internal controls to the administrator. The submission shall be made at least 30 days before fantasy sports contest operations are to commence unless otherwise approved by the administrator. All internal controls must be approved by the administrator prior to commencement of contest operations. The service provider shall submit to the administrator any changes to the internal controls previously approved at least 15 days before the changes are to become effective unless otherwise directed by the administrator. It shall be the affirmative responsibility and continuing duty of each licensee and its employees to follow and comply with all internal controls. The submission shall include controls and reasonable methods that comply with and provide for:

a. Prevention of employees of the internet fantasy sports contest service provider and relatives living in the same household of such employees from competing in any internet fantasy sports contest on the service provider's digital platform in which the service provider offers a prize to the public.

b. Verification that any fantasy sports contest player is 21 years of age or older.

c. Restriction of entries from coaches, officials, athletes, contestants, or other individuals who participate in a game or contest that is the subject of an internet fantasy sports contest in which the outcome is determined, in whole or in part, by the accumulated statistical results of a team of individuals in the game or contest in which they participate.

d. An easy and obvious method for a player to make a complaint and to enable the player to notify the commission if such complaint has not been or cannot be resolved by the licensee.

e. Measures used to determine the true identity, date of birth, and address of each player seeking to open an account.

f. Standards and procedures used to monitor fantasy sports contests to detect the use of unauthorized scripts and restrict players found to have used such scripts from further fantasy sports contests.

g. Prevention of unauthorized withdrawals from a registered player's account by the service provider or others.

h. How the service provider will accept wagers within the permitted boundary.

i. How the service provider will segregate fantasy sports contest player funds from operational funds.

j. Protection of a fantasy sports contestant's personal and private information.

**14.8(2) Records.** Licensees shall provide all information requested by the commission. Access to this information shall be immediate, and copies of the information shall be delivered within seven days or less as ordered by the commission. The licensees shall ensure all books and records and their retention comply with 491—subrule 5.4(14). All records pertaining to contests shall be available to allow for player complaint resolution.

**14.8(3) Reporting.** The licensee shall provide prompt notification of any facts which the licensee has reasonable grounds to believe indicate a violation of law or commission rule committed by licensees, their key persons, or their employees, including without limitation the performance of licensed activities different from those permitted under their license. The licensee is also required to provide a detailed written report within seven business days, or a time frame otherwise approved by the administrator, from the discovery for any of the following:

- a. Criminal or disciplinary proceedings commenced against the service provider in connection with its operations;
- b. Abnormal contest activity or patterns that may indicate a concern about the integrity of an internet fantasy sports contest;
- c. Any other conduct with the potential to corrupt an outcome of an internet fantasy sports contest for purposes of financial gain, including but not limited to match fixing;
- d. Suspicious or illegal internet fantasy sports contest activities, including the use of funds derived from illegal activity, deposits of money to enter an internet fantasy sports contest to conceal or launder funds derived from illegal activity;
- e. The use of agents to enter an internet fantasy sports contest or use of false identification.

**14.8(4) Technical and testing requirements.**

a. *Initial testing.* All equipment and systems integral to the conduct of fantasy sports contests shall be tested and certified for compliance with commission rules and the standards required by a commission-designated independent testing laboratory. Certification and commission approval must be received prior to the use of any equipment or system to conduct a fantasy sports contest. The commission may designate more than one independent testing laboratory.

b. *Change control.* The fantasy sports contest service providers shall submit change control processes that detail evaluation procedures for all updates and changes to equipment and systems to the administrator for approval. These processes shall include details for identifying criticality of updates and determining of submission of updates to an independent testing laboratory for review and certification.

c. *Annual testing.*

(1) A system integrity and security risk assessment shall be performed annually on the fantasy sports contest system.

1. The testing organization must be independent of the licensee and shall be qualified by the administrator.

2. The system integrity and security risk assessment shall be conducted no later than 90 days after the start of the licensee's fiscal year.

3. Results from the risk assessment shall be submitted to the administrator no later than 30 days after the assessment is conducted.

(2) At the discretion of the administrator, additional assessments or specific testing criteria may be required.

d. *Limit on number of websites and platforms.* A fantasy sports contest service provider is authorized to conduct no more than two websites or platforms maintained and operated by the service provider.

**14.8(5) Operating requirements.** A fantasy sports contest service provider shall ensure the following:

a. Players winning fantasy sports contests shall have winning funds deposited into their player account or be paid by other means approved by the administrator within 48 hours from the end of the contest. Players shall have a fee-free method to deposit or withdraw funds from their player account. If

funds are unable to be placed in a player's account, the fantasy sports contest service provider shall mail the funds to the player's address on file within ten days.

*b.* Player withdrawal of funds maintained in the player account shall be completed within five business days of the request unless the licensed fantasy sports contest service provider believes, in good faith, that the player engaged in fraud or other illegal activity pursuant to Iowa Code chapter 99D, 99E or 99F.

*c.* Procedures allow for a player to close an account and to access the player's history, including all fantasy sports contests in which the player participated.

*d.* Employees of the licensee are prohibited from participation in any fantasy sports contest offered by the licensee in which a cash prize is offered to the public. This includes prohibiting relatives living in the same household as such employees from competing in any fantasy sports contests offered by any licensee.

*e.* Prohibition of the sharing of confidential information that could affect fantasy sports contest play with third parties until the information is made publicly available.

*f.* Players are allowed to voluntarily self-exclude in compliance with Iowa Code section 99F.4(22), and a fantasy sports contest service provider shall follow all resolutions associated with the process. [ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20; ARC 5423C, IAB 2/10/21, effective 3/17/21]

#### **491—14.9(99E) Contest rules.**

**14.9(1)** Prior to conducting a new type of fantasy sports contest, a fantasy sports contest service provider shall submit proposed contest rules to the administrator. The contest submission shall be in writing and approved by the administrator prior to implementation. The administrator shall approve, deny, or request further information within three business days of submission. If the administrator takes no action within that period, the fantasy sports contest service provider may offer the requested contest unless the administrator issues a subsequent disapproval. Once a contest is approved, the contest is available for all fantasy sports contest service providers unless the contest format is subsequently disapproved by the administrator for any reason the commission deems appropriate. Fantasy sports contest service providers may offer minor variations of an approved contest type without seeking administrator approval. Minor variations include:

*a.* Offering the contest format for any sport, league, association or organization previously approved by the administrator for any fantasy sports contest type;

*b.* The size of the contest and number of entries permitted;

*c.* Nonmaterial changes to entry fee and prize structure;

*d.* The number of athletes that a contestant selects to fill a roster when completing an entry;

*e.* The positions that must be filled when completing an entry;

*f.* Adjustments to the scoring system; and

*g.* Adjustments to a salary cap.

**14.9(2)** Licensees are required to comply with and ensure the following:

*a.* Advertisements for contests and prizes offered by a licensee shall not target prohibited participants, underage persons, or self-excluded persons.

*b.* The values of all prizes and awards offered to winning players must be established and made known to the players in advance of the contest.

*c.* Introductory procedures for players are prominently displayed on the main page of the licensee's platform to explain contest play and how to identify a highly experienced player.

*d.* Identification of all highly experienced players in every fantasy sports contest by a symbol attached to the players' usernames, or by other easily visible means, on all platforms supported by the licensee.

*e.* Contests are not offered based on the performance of participants in high school or youth sports events. However, until May 1, 2020, "fantasy sports contest" does not include any fantasy or simulated game or contest in which any winning outcomes are based on statistical results from a collegiate sporting event as defined in Iowa Code section 99E.1.

*f.* Representations or implications about average winnings from contests shall not be unfair or misleading.

*g.* Prohibition of the use of unauthorized third-party scripts or unauthorized scripting programs for any contest and ensure that measures are in place to deter, detect, and prevent cheating to the extent reasonably possible. “Cheating” includes collusion and the use of cheating devices, including the use of software programs that submit entry fees or adjust the athletes selected by a player.

*h.* Prominent display of information about the maximum number of entries that may be submitted for that contest for all advertised fantasy sports contests.

*i.* Disclosure of the number of entries that a player may submit to each fantasy sports contest and provide reasonable steps to prevent players from submitting more than the allowable number.

*j.* Opportunity for players to file a patron dispute.

*k.* Conspicuously disclose the source of the data utilized in any results.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

#### **491—14.10(99E) Segregation account requirements and financial reserves.**

**14.10(1) Segregation.** Fantasy sports contest service providers shall segregate all fantasy sports contest player funds from operational funds.

**14.10(2) Financial reserves.** For the protection of the funds of contest participants held in paid fantasy sports accounts, the fantasy sports contest service provider shall maintain a reserve in the form of cash, cash equivalents, an irrevocable letter of credit, payment processor reserves and receivables, a bond, or a combination thereof in the amount of the deposits in internet fantasy sports contest player accounts.

*a.* The method of reserve shall be submitted and approved by the commission prior to implementation.

*b.* The amount of the reserve shall be equal to, at a minimum, the sum of all registered players’ funds held in player accounts originating in Iowa.

*c.* If, at any time, the licensee’s total available cash and cash equivalent reserve is less than the amount required, the licensee shall notify the commission of this deficiency within 48 hours.

*d.* Each licensee shall continuously monitor and maintain a record of all player deposits and the licensee’s cash reserves to ensure compliance with the cash reserves requirement.

*e.* The licensee shall provide the commission with documentation including the amount of deposits in players’ accounts and the amount in cash reserves as of the last day of each month. The information is due by the fifteenth day of the month for the preceding month.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—14.11(99E) Annual audit.** An audit of the fantasy sports contest operations for the licensee or parent company of the licensee shall be conducted by certified public accountants authorized to practice in the state of Iowa and provided to the commission within 180 days of the licensee’s fiscal year and meet the following conditions:

**14.11(1)** Inclusion of an internal control letter, audited balance sheet, and audited profit-and-loss statement including a breakdown of expenditures and subsidiaries of fantasy sports contest activities.

**14.11(2)** Inclusion of a supplement schedule indicating financial activities on a calendar-year basis if the licensee’s fiscal year does not correspond to the calendar year.

**14.11(3)** Report of any material errors, irregularities that may be discovered during the audit, or notice of any audit adjustments.

**14.11(4)** Availability, upon request, of an engagement letter for the audit between the licensee or parent company of the licensee and the auditing firm.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

#### **491—14.12(99E) Abandoned accounts.**

**14.12(1)** Abandoned player accounts under this rule are subject to Iowa Code chapter 556. Player accounts are considered abandoned if no activity by the account holder has occurred for three years. Player activity includes entering a contest, making an account deposit, or withdrawing funds.

**14.12(2)** No internet fantasy sports contest service provider shall charge an administration fee or maintenance fee for any inactive player account derived from state of Iowa residents at any time for any reason.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—14.13(99E) Problem gambling.**

**14.13(1)** The licensee shall adopt and implement the following:

*a.* Policies and procedures designed to identify compulsive play.

*b.* Policies and procedures designed to comply with the process established by the commission pursuant to Iowa Code section 99F.4(22).

*c.* Policies and procedures designed to cooperate with the Iowa gambling treatment program in creating and establishing controls.

*d.* Policies and procedures designed to make information available to customers concerning assistance for compulsive play in Iowa, including websites or toll-free numbers directing customers to reputable resources containing further information, which shall be free of charge.

*e.* A process to easily and prominently impose limitations or notifications for deposits and monetary participation in a contest. Upon receipt, any self-imposed limits must be employed correctly and immediately as indicated to the player. No changes can be made reducing the severity of the self-imposed limitations for at least 24 hours.

*f.* A process to easily and prominently self-exclude for a specified period of time or indefinitely and easily and obviously direct participants, via a link, to exclude themselves pursuant to Iowa Code section 99F.4(22). Upon receipt, any self-exclusion limits must be employed correctly and immediately as indicated to the player. No changes can be made to reduce the severity of the self-exclusion limitations for at least 24 hours. In the event of indefinite self-exclusion, the licensee must ensure that the player is paid in full for the player's account balance within a reasonable time provided that the licensee acknowledges that the funds have cleared. This control does not supersede the requirements set forth in Iowa Code section 99F.4(22).

*g.* A process to review and deactivate accounts of newly enrolled participants of the statewide self-exclusion program set forth in Iowa Code section 99F.4(22). The licensee must ensure that the player is paid in full for the player's account balance provided that the licensee acknowledges that the funds have cleared.

**14.13(2)** The licensee shall also include on the internet site or mobile application the statewide telephone number of the Iowa department of public health to provide problem gambling information and extensive responsible gaming features in addition to those described in Iowa Code section 99F.4(22).

**14.13(3)** Money forfeited by a voluntarily excluded person pursuant to Iowa Code section 99F.4(22) shall be withheld by the licensee and remitted to the general fund of the state by the licensee.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

**491—14.14(99E) Licensing of internet fantasy sports contest service providers.**

**14.14(1) Operation.** The internet fantasy sports contest service provider shall submit the following for commission approval:

*a.* Internal controls for the operation of the account.

*b.* A detailed description and certification of systems and procedures used by the internet fantasy sports contest service provider to validate the identity, age and location of licensee account holders and to validate the legality of wagers accepted.

*c.* Certification of secure retention of all records related to internet fantasy sports contests and accounts for a period of not less than three years or such longer period as specified by the commission.

*d.* Certification of prompt commission access to all records relating to account holder identity, age and location in hard-copy or standard electronic format acceptable to the commission.

*e.* Verification that the player is not on the statewide voluntary self-exclusion list set forth in Iowa Code section 99F.4(22) prior to establishing an account.

**14.14(2) Record keeping.**

*a.* Record storage required. Internet fantasy sports contest service providers shall maintain adequate records of business operations, which shall be made available to the administrator upon request. These records shall include:

(1) All correspondence with the administrator and other governmental agencies on the local, state, and federal level.

(2) All correspondence between the licensee and any of its customers who are applicants or licensees under Iowa Code chapter 99E.

(3) Financial records of all transactions with players and all other licensees under these regulations.

*b.* Record retention. The records listed in paragraph 14.14(2) “*a*” shall be retained as required by 491—subrule 5.4(14).

**14.14(3)** *Violation of laws or regulations.* Violation of any provision of any laws of the state or of the United States of America or of any rules of the commission may constitute an unsuitable method of operation, subjecting the licensee to limiting, conditioning, restricting, revoking or suspending the license, or fining the licensee, or any combination of the above. The commission has the discretion to suspend fantasy sports contest operations of its licensees by written order if necessary.

[ARC 4618C, IAB 8/28/19, effective 7/31/19; ARC 5016C, IAB 4/8/20, effective 5/13/20]

These rules are intended to implement Iowa Code chapters 99D, 99E and 99F.

[Filed Emergency ARC 4618C, IAB 8/28/19, effective 7/31/19]

[Filed ARC 5016C (Amended Notice ARC 4807C, IAB 12/18/19; Notice ARC 4617C, IAB 8/28/19),  
IAB 4/8/20, effective 5/13/20]

[Filed ARC 5422C (Notice ARC 5269C, IAB 11/18/20), IAB 2/10/21, effective 3/17/21]

[Filed ARC 5423C (Notice ARC 5315C, IAB 12/16/20), IAB 2/10/21, effective 3/17/21]

## **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 4  
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

**761—4.1(22,305) General provisions.**

**4.1(1) Scope of chapter.**

*a.* This chapter describes the provisions governing public access to records that are owned by or in the physical possession of the department. However, access to personnel and payroll records may also be subject to the rules of the department of administrative services.

*b.* This chapter does not affect the policy of the department to respond, without charge, to routine oral or written inquiries that do not involve the furnishing of records.

*c.* This chapter does not make available records compiled by the department in reasonable anticipation of court litigation or formal administrative proceedings. The availability of these records to the public or to any individual or party to such litigation or proceedings shall be governed by applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable regulations of the department.

**4.1(2) Custodian.** The custodian of a record is the person who heads the departmental office responsible for that record. The department's electronic Records Management Manual identifies the offices that are responsible for particular records.

*a.* As used in this chapter, the term "custodian" includes the custodian's superiors and the custodian's designees.

*b.* A custodian's designee may include but is not limited to the records center.

*c.* The custodian of a record is authorized to provide or deny access to that record in accordance with the provisions of this chapter. However, the custodian's authority to provide access to a confidential record is limited to the persons listed in subrule 4.4(2).

**4.1(3) Address of records center.** The address of the department's records center is: Records Management Section, Information Technology Division, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

**4.1(4) Records Management Manual.**

*a.* The department's electronic Records Management Manual contains the records management information required by Iowa Code chapter 305, including descriptions of department records and their formats, management, maintenance, storage, retention, security, and disposal.

*b.* The manual also contains the descriptive information on records that is required by Iowa Code section 22.11. The manual is updated as needed and its provisions are made a part of these rules.

*c.* The manual is available for examination and copying at the department's records center and at various other departmental offices located throughout the state. A copy of the manual may also be obtained, upon request, from the records center.

**4.1(5) Availability of open records.** Open records of the department are available to the public for examination and copying unless otherwise provided by state or federal law, regulation or rule.

**4.1(6) Data processing matching.** All departmental data processing systems that have common data elements can potentially match, collate and compare personally identifiable information.

**4.1(7) Warranty.** No warranty of the accuracy or completeness of a record is made.

**4.1(8) Existing records.** A request for access shall apply only to records that exist at the time the request is made and access is provided. The department is not required to create, compile or procure a record solely for the purpose of making it available. EXCEPTIONS: See Iowa Code section 22.3A and subrule 4.4(4).

**4.1(9) Definitions.** As used in this chapter:

"Confidential record" means a record that 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 records or information contained in records that the department is prohibited by law from making available for examination by members of the public, and records or information contained in records that are specified as confidential by Iowa Code section 22.7 or another provision of law, but that may be disclosed upon order of the court, the 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.

*“Open record”* means a record other than a confidential record.

*“Personally identifiable information”* means information about an individual in a record that identifies the individual and is retrievable by a unique personal identifier associated with the individual.

*“Public”* means those persons who are not officials, employees or agents of the department.

*“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.

*“Requester”* means a member of the public.

This rule is intended to implement Iowa Code chapter 22 and section 305.15.

[ARC 7909B, IAB 7/1/09, effective 7/1/09; ARC 2049C, IAB 7/8/15, effective 8/12/15]

**761—4.2(22) Statement of policy and purpose.** It is the policy of the department that free and open examination of public records is generally in the public interest. The purpose of these rules is to facilitate broad public access to open records and sound determinations with respect to the handling of confidential records.

This rule is intended to implement Iowa Code chapter 22.

**761—4.3(22) Access to records.**

**4.3(1) Submission of request for access.**

*a.* A request for access to a record shall be submitted to the custodian of the record. If the requester does not know the identity of the custodian, the request may be submitted to the records center at the address in subrule 4.1(3). The records center will forward the request to the custodian.

*b.* Notwithstanding paragraph “*a*” of this subrule, any request that may be related to a potential or an actual tort claim or other litigation shall be submitted to: General Counsel, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010. If the custodian receives a request of this nature, the custodian shall forward the request to the department’s general counsel.

*c.* If a request for access is misdirected, department personnel will forward the request to the custodian.

**4.3(2) Office hours.** Open records are available during customary office hours, which are 8 a.m. to 4:30 p.m., excluding Saturdays, Sundays, and legal holidays.

**4.3(3) Form of request.** A request for access to a record shall reasonably describe the record requested. A request for access to an open record may be made in person, in writing, by telephone, or by electronic means. A requester shall not be required to give reasons for requesting an open record.

**4.3(4) Response to request.** The custodian shall provide access to an open record promptly upon request. However, if the size or nature of the request makes prompt access infeasible, the custodian shall fill the request as soon as feasible and give the requester an estimate of when the record will be available.

**4.3(5) Delay.** Access to a record may be delayed for one of the purposes authorized by Iowa Code subsection 22.8(4) or 22.10(4). The custodian shall inform the requester of the reason for the delay and the estimated length of the delay.

**4.3(6) Security of records.** No person may, without permission from the custodian, search agency files or remove any record copy from the place where it is made available. The custodian shall supervise the examination and copying of records and protect the records from damage and disorganization. Original paper records shall be released from department custody only upon court order. The custodian shall place at least one certified copy in the file if the original record is released.

**4.3(7) Copies.** A photocopy of an open record may be made on department photocopiers. If a photocopier is not available in the office where an open record is kept, the custodian shall permit its examination in that office and, if requested, arrange to have a copy made elsewhere. Most department records are stored in electronic formats; therefore, if the requested record is electronic, an electronic copy will be provided. If the requester is unable to open and read an electronic copy, or if the record does not exist in electronic form, a hard copy will be provided.

**4.3(8) Fees.** The department may charge fees for records as authorized by Iowa Code section 22.3 or another provision of law. Under Iowa Code section 22.3, the fee for the copying service, whether electronic or hard copy, shall not exceed the cost of providing the service.

This rule is intended to implement Iowa Code sections 22.2, 22.3, 22.4, 22.8, 22.10, and 22.11. [ARC 2049C, IAB 7/8/15, effective 8/12/15; ARC 5424C, IAB 2/10/21, effective 3/17/21]

**761—4.4(22) Access to confidential records.** The following provisions are in addition to those specified in rule 761—4.3(22) and are minimum requirements. A statute or another department rule may impose additional requirements for access to certain classes of confidential records. A confidential record may, due to its nature or the way it is compiled or stored, contain a mixture of confidential and nonconfidential information. The department shall not refuse to release the nonconfidential information simply because of the manner in which the record is compiled or stored.

**4.4(1) Procedure.**

*a. Form of request.* The custodian shall ensure that there is sufficient information to provide reasonable assurance that access to a confidential record may be granted. Therefore, the custodian may require the requester to:

- (1) Submit the request in writing.
- (2) Provide proof of identity and authority to secure access to the record.
- (3) Sign a certified statement or affidavit listing the specific reasons justifying access to the record and provide any proof necessary to establish relevant facts.

*b. Response to request.* The custodian shall notify the requester of approval or denial of the request for access. If the requester indicates to the custodian that a written notice is desired if the request for access is denied, the custodian shall provide such notice promptly. The notice shall be signed by the custodian and include:

- (1) The name and title or position of the custodian, and
- (2) A brief statement of the grounds for denial, including a citation to the applicable statute or other provision of law.

*c. Reconsideration of denial.* A requester whose request is denied by the custodian may apply to the director of transportation for reconsideration of the request.

**4.4(2) Release of confidential records by the custodian.** The custodian may release a confidential record or a portion of it:

- a.* To the legislative services agency pursuant to Iowa Code section 2A.3.
- b.* To the ombudsman pursuant to Iowa Code section 2C.9.
- c.* To other governmental officials and employees only as needed to discharge their duties.
- d.* To those persons as permitted or required by rule 761—4.9(22).
- e.* To persons authorized by the subject of the record in accordance with rule 761—4.5(22).
- f.* To the public information board pursuant to Iowa Code section 23.6.

**4.4(3) Release of confidential records by the director.** Rescinded IAB 9/11/19, effective 10/16/19.

**4.4(4) Information released.** If a person is provided access to less than an entire record, the department shall take measures to ensure that the person is furnished only the information that is to be released. This may be done by providing to the person either an extraction of the information to be released or a copy of the record from which the information not to be released has been deleted.

This rule is intended to implement Iowa Code section 22.11. [ARC 2049C, IAB 7/8/15, effective 8/12/15; ARC 3026C, IAB 4/12/17, effective 5/17/17; ARC 4659C, IAB 9/11/19, effective 10/16/19]

**761—4.5(22) Consent to release a confidential record to a third party.** To the extent permitted by law, the subject of a confidential record may consent to its release to a third party. The consent must be in writing and must identify the particular record that may be disclosed and the particular person or class of persons to whom the record may be disclosed. The subject of the record may be required to provide proof of identity. Appearance of counsel before the agency on behalf of a person who is the subject of

a confidential record may be deemed to constitute consent for the department to disclose records about that person to the person's counsel.

This rule is intended to implement Iowa Code section 22.11.

**761—4.6(22) Requests for confidential treatment.**

**4.6(1)** A person may request that all or a portion of a record be confidential. The request must be submitted in writing to the custodian and:

- a. Identify the information for which confidential treatment is sought.
- b. Cite the legal basis that justifies confidential treatment.
- c. Demonstrate that disclosure of the information would clearly not be in the public interest.
- d. Give the reasons why any person or persons would be substantially and irreparably injured by disclosure of the information. The requester may be required to provide any proof necessary to support these reasons.

**4.6(2)** The custodian shall notify the requester in writing of the granting or denial of the request and, if denied, the reasons therefor.

**4.6(3)** If the request is denied, the requester may apply to the director of transportation for reconsideration of the request.

This rule is intended to implement Iowa Code sections 22.8 and 22.11.

[ARC 2049C, IAB 7/8/15, effective 8/12/15]

**761—4.7(22) Procedure by which additions, dissents, or objections may be entered into records.** Except as otherwise provided by law, the person who is the subject of a record may have a written statement of additions, dissents or objections entered into that record. The statement shall be filed with the custodian. The statement must be dated and signed by the person who is the subject of the record and include the person's current address and telephone number. This rule does not authorize the person who is the subject of the record to alter the original record or to expand the official record of any agency proceeding.

This rule is intended to implement Iowa Code section 22.11.

**761—4.8(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 the use that will be made of the information, which persons outside the agency 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. This notice may be given in these or other rules of the department, 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, orally, or by other appropriate means.

This rule is intended to implement Iowa Code section 22.11.

**761—4.9(22) Confidential records.** This rule describes the types of departmental information or records that are confidential. This rule is not exhaustive. A citation of the legal authority for confidentiality follows each description. The following records shall be kept confidential. Records are listed by category, according to the legal basis for withholding them from public inspection.

Descriptions:

**4.9(1)** Records which are exempt from disclosure under Iowa Code section 22.7.

**4.9(2)** Records which constitute attorney work product, attorney-client communications, or are otherwise privileged. (Attorney work product is confidential under Iowa Code sections 22.7, 622.10 and 622.11, Iowa R. C. P. 1.503, Fed. R. Civ. P. 26(b)(3), and case law. Attorney-client communications are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, the Iowa Rules of Professional Conduct, and case law.)

**4.9(3)** Those portions of the department's staff manuals, instructions or other statements issued by the department which set forth criteria or guidelines to be used by its departmental staff in auditing, making inspections, settling commercial disputes or negotiating commercial arrangements, or in the selection or handling of cases, such as operational tactics or allowable tolerances or criteria for the

defense, prosecution or settlement of cases, when the disclosure of such statements would enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons who are in an adverse position to the department. (Iowa Code sections 17A.2 and 17A.3)

**4.9(4)** The detailed minutes and recordings of closed sessions of the commission. However, if a closed session regards a real estate purchase or sale, the minutes and recording shall be available for public inspection when the transaction discussed is completed. (Iowa Code section 21.5)

**4.9(5)** Vehicle accident reports submitted to the department by drivers and peace officers. (Iowa Code sections 321.266 and 321.271)

- a. However, access shall be granted to those persons authorized by Iowa Code section 321.271.
- b. Reserved.

**4.9(6)** Unless otherwise ordered by the court, all information filed with the court for the purpose of securing a warrant for an arrest including, but not limited to, a citation and affidavits, until such time as a peace officer has made the arrest and has made the officer's return on the warrant, or the defendant has made an initial appearance in court. (Iowa Code section 804.29)

a. However, the information in the record may be disseminated without court order during the course of official duties to the persons authorized in Iowa Code section 804.29 unless access to such information is expressly denied by court order.

- b. Reserved.

**4.9(7)** All information filed with the court for the purpose of securing a warrant for a search, including, but not limited to, an application and affidavits, until such time as a peace officer has executed the warrant and has made return thereon. (Iowa Code section 808.13)

a. During the period of time that information is confidential, it shall be sealed by the court, and the information contained therein shall not be disseminated to any person other than a peace officer, magistrate or other court employee, in the course of official duties.

- b. Reserved.

**4.9(8)** Information obtained by the department from the examining of reports, returns or records required to be filed or kept under the provisions of Iowa Code chapter 452A, except where disclosure is authorized by Iowa Code chapter 452A. (Iowa Code section 452A.63)

**4.9(9)** Sealed bids, until the time set for the public opening of bids, whereupon bids are unsealed and no longer confidential. (Iowa Code section 72.3)

**4.9(10)** Those records which, if disclosed, would diminish competition or would give an improper advantage to persons who are in an adverse position to the department. These records shall be kept confidential until the transaction to which they relate is consummated. However, if disclosure would reveal information which would hinder future competition, the records shall be kept confidential. (Iowa Code sections 17A.2, 17A.3, 22.7 and 313.10, Iowa Code chapter 553, and 761—Chapter 20)

a. Examples of records which could, in the proper circumstances, be determined to be within this category include, but are not limited to:

- (1) Detailed estimates of the cost of a proposed contract.
- (2) Economic analyses for determining pavement types.
- (3) Negotiations for a proposed contract.
- (4) Methodology for determining unfair bidding practices or bid rigging.
- (5) Price quotations solicited.
- (6) The value of points assigned to a bid rating formula prior to the time set for public opening of bids.

(7) Laboratory testing reports of suppliers' products. These may also be trade secrets. The subject of the report has the right of access to it.

- b. Reserved.

**4.9(11)** Audit reviews for determining equal employment opportunity contract compliance. (Iowa Code section 22.7 and 5 U.S.C. §§ 552 and 552a)

- a. The subject of the audit review has the right of access to it.
- b. Reserved.

**4.9(12)** All financial records and any information contained within them that are made available to the department, unless otherwise expressly permitted to be divulged by federal or state law. (Iowa Code sections 22.7 and 422.20 and 5 U.S.C. §§ 552 and 552a)

**4.9(13)** Personal information in any motor vehicle record, including personal information contained on electronic driver's license or nonoperator's identification card records that is provided by the licensee or card holder to the department for use by law enforcement, first responders, emergency medical service providers, and other medical personnel responding to or assisting with an emergency. (Iowa Code sections 22.7 and 321.11 and 18 U.S.C. § 2721 et seq.)

*a.* Information other than personal information contained on electronic driver's license or nonoperator's identification card records that is provided by the licensee or card holder to the department for use by law enforcement, first responders, emergency medical service providers, and other medical personnel responding to or assisting with an emergency may be disclosed only as provided in Iowa Code sections 321.11 and 321.11A, 18 U.S.C. § 2721 et seq., and 761—Chapters 415, 610 and 611.

*b.* The subject of the personal information has the right of access to the information.

**4.9(14)** A report received by the department from a physician licensed under Iowa Code chapter 148, an advanced registered nurse practitioner licensed under Iowa Code chapter 152 and licensed with the board of nursing, a physician assistant licensed under Iowa Code chapter 148C or an optometrist licensed under Iowa Code chapter 154 regarding a person who has been diagnosed as having a physical or mental condition which would render the person physically or mentally incompetent to operate a motor vehicle in a safe manner. (Iowa Code section 321.186)

**4.9(15)** Privileged and personnel records or information of law enforcement officers and undercover law enforcement officers, as specified in Iowa Code sections 80G.2 and 80G.3, as well as certain records regarding undercover driver's licenses issued to certified peace officers employed by a local authority or by the state or federal law enforcement officers, as specified in 761—Chapter 625. (Iowa Code sections 22.7, 80G.2, 80G.3 and 321.189A)

*a.* The subject of the record and the head of the law enforcement agency employing the subject have the right of access to the record.

*b.* Reserved.

**4.9(16)** Records related to confidential plates issued for government vehicles. (Iowa Code section 321.19)

*a.* The head of the agency to which the vehicle is assigned has the right of access to the record.

*b.* Reserved.

**4.9(17)** Certified transcripts of labor payrolls (also known as certified payroll records) filed by contractors for federal-aid construction contracts, in accordance with the following paragraphs. (Iowa Code section 22.7, 5 U.S.C. §§ 552 and 552a, and 42 U.S.C. § 405)

*a.* The social security numbers in a certified payroll record are confidential. The record itself may be confidential if its release would give advantage to competitors and serve no public purpose.

*b.* The prime contractor and subcontractor, if applicable, that filed the record have the right of access to it.

*c.* Certified payroll records shall be released to the U.S. Department of Labor and Federal Highway Administration during investigations.

*d.* The custodian may release a certified payroll record with social security numbers withheld to representatives of the Iowa Labor Management Work Preservation Fund.

*e.* The custodian may release a certified payroll record with social security numbers withheld to persons outside the department other than the persons listed in paragraphs 4.9(17) "b" to "d" according to the following procedure:

(1) The request for the record must be in writing.

(2) The custodian shall send a copy of the request by registered mail to the prime contractor. If the request is for subcontractor information, the custodian shall send copies of the request to both the subcontractor and prime contractor.

(3) The requested record shall not be released until 14 calendar days have expired from receipt of the request by the contractor(s) to give the contractor(s) an opportunity to seek an injunction.

**4.9(18)** Information concerning an open or pending railroad accident investigation conducted on behalf of or in conjunction with the Federal Railroad Administration or National Transportation Safety Board to the extent necessary to prevent denial of funds, services or essential information from the United States government. (Iowa Code section 22.9)

**4.9(19)** A geographic computer database, except upon terms and conditions acceptable to the department. (Iowa Code section 22.2)

**4.9(20)** Confidential information, as defined in Iowa Code section 86.45, filed with the workers' compensation commissioner. (Iowa Code section 22.7)

**4.9(21)** An intelligence assessment and intelligence data under Iowa Code chapter 692, except where disclosure is required or authorized by the Iowa Code. (Iowa Code chapter 692 and Iowa Code section 22.7)

**4.9(22)** Information in a record that would permit the commission, subject to Iowa Code chapter 21, to hold a closed session pursuant to Iowa Code section 21.5 in order to avoid public disclosure of that information, until such time as final action is taken on the subject matter of that information or unless otherwise authorized by the Iowa Code. (Iowa Code section 22.7)

**4.9(23)** Rescinded IAB 9/11/19, effective 10/16/19.

**4.9(24)** All other information or records that by law are or may be confidential.

This rule is intended to implement Iowa Code chapters 22, 553 and 692; Iowa Code sections 17A.2, 17A.3, 21.5, 72.3, 80G.2, 80G.3, 313.10, 321.11, 321.11A, 321.19, 321.186, 321.189A, 321.266, 321.271, 422.20, 452A.63, 622.10, 622.11, 804.29 and 808.13; 5 U.S.C. §§ 552 and 552a; 18 U.S.C. § 2721 et seq.; and 42 U.S.C. § 405.

[ARC 2049C, IAB 7/8/15, effective 8/12/15; ARC 3026C, IAB 4/12/17, effective 5/17/17; ARC 4659C, IAB 9/11/19, effective 10/16/19; ARC 5424C, IAB 2/10/21, effective 3/17/21]

**761—4.10(22) Release of confidential records.** Rescinded IAB 1/8/03, effective 2/12/03.

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CHAPTER 121  
ADOPT-A-HIGHWAY PROGRAM

**761—121.1(307) Purpose.** These rules describe the adopt-a-highway program and the procedure for applying to participate in the program.

**761—121.2(307) Information.** Information relating to the adopt-a-highway program may be obtained online at [www.iowadot.gov](http://www.iowadot.gov). Assistance is available by mail from the Maintenance Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010 or by telephone at (515)239-1971. [ARC 5425C, IAB 2/10/21, effective 3/17/21]

**761—121.3(307) Program guidelines.**

**121.3(1)** The adopt-a-highway program allows individuals or groups to assume responsibility for performing litter pickup for a specific segment of highway.

**121.3(2)** All primary roads, including interstate highways, under the jurisdiction of the department shall be eligible for participation in the adopt-a-highway program. [ARC 5425C, IAB 2/10/21, effective 3/17/21]

**761—121.4(307) Sponsors.**

**121.4(1) Eligible sponsors.** Communities, organizations and individuals are eligible to participate in the adopt-a-highway program.

**121.4(2) Ineligible sponsors.** The department shall not grant sponsorship of a highway section in the adopt-a-highway program if the sponsorship might be deemed a partisan endorsement by the state or have an adverse effect on the program.

**121.4(3) Discrimination prohibited.** Eligible sponsors must comply with all applicable laws prohibiting discrimination based on age, race, creed, color, sex, sexual orientation, gender identity, national origin, religion or disability. [ARC 2570C, IAB 6/8/16, effective 7/13/16]

**761—121.5(307) Eligible activities.** Rescinded ARC 5425C, IAB 2/10/21, effective 3/17/21.

**761—121.6(307) Procedure.**

**121.6(1) Application.** The adopt-a-highway webpage located on the department's website at [www.iowadot.gov](http://www.iowadot.gov) contains a link to an online adopt-a-highway permit application form. After a prospective sponsor applies online, the department will review the application and contact the prospective sponsor by telephone or email.

**121.6(2) Selection.** If more than one individual or group applies to adopt a specific highway segment, the department shall determine the sponsor.

**121.6(3) Termination.** If the department determines that a sponsor is not fulfilling the terms and conditions of the agreement, the department may terminate the sponsorship. [ARC 5425C, IAB 2/10/21, effective 3/17/21]

These rules are intended to implement Iowa Code section 307.24.

[Filed 3/13/90, Notice 1/24/90—published 4/4/90, effective 5/9/90]

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[Filed ARC 5425C (Notice ARC 5245C, IAB 11/4/20), IAB 2/10/21, effective 3/17/21]



CHAPTER 131  
SIGNING ON PRIMARY HIGHWAYS  
[Prior to 6/3/87, Transportation Department[820]—(06,K) Ch 3]

**761—131.1(321) Destination signs at an intersection.** This rule establishes the requirements and procedure for placing destination signs on a primary highway at the intersection of a secondary road.

**131.1(1) Requirements.**

*a.* A destination shown on a primary highway destination sign shall be one reached by following either the secondary road or the primary highway.

*b.* A secondary road destination shall not be located beyond the next primary highway.

*c.* The secondary road must be marked with sufficient route markers, arrows, and destination signs to guide a motorist through intersecting roads, winding roads and built-up areas.

*d.* To qualify for signing, a secondary road destination must be one of the following:

(1) Another primary highway.

(2) An incorporated community.

(3) An unincorporated village shown on the state transportation map.

(4) A publicly maintained park.

(5) A public-use or publicly owned airport.

(6) A historical site recognized and approved by the department of cultural affairs.

*e.* The department shall determine which primary highway destinations qualify for signing.

**131.1(2) Procedure.**

*a.* To request placement of destination signs at the intersection of a primary highway and a secondary road, the county engineer shall obtain Form 740023, "Proposed Directional Signing," from the appropriate district office, complete it and submit it to the appropriate district office. The county engineer may request signs for destinations on the secondary road that meet the criteria in paragraph 131.1(1) "d" and destinations on the primary highway.

*b.* If destination signs are already in place at the intersection, any person may request listing additional destinations by submitting a written request to the traffic and safety bureau.

*c.* The traffic and safety bureau shall determine if a request is to be approved or denied and notify the requester of its action on the request.

*d.* The department shall install and maintain the primary highway destination signs. The department shall also furnish primary route markers and auxiliary signs for installation on the secondary road and install secondary road route markers and auxiliary signs furnished by the county on the primary highway.

[ARC 1986C, IAB 5/13/15, effective 6/17/15; ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.2(321) Erection of signs for numbered business routes.** This rule establishes signing requirements, responsibilities and procedures for the erection of signs for numbered business routes.

**131.2(1) Definition.** A business route is a route principally within the corporate city limits which provides the public a marked route through the business area of the city as an alternate to the regular route which bypasses the city or its congested area.

**131.2(2) Requirements.**

*a.* The business route must connect with the regular route outside the congested area or the corporate limits, but within a reasonable distance of those limits.

*b.* The route must be designated over paved streets and highways which are available to all types of vehicles.

**131.2(3) Responsibilities.**

*a.* All business route identification signs, including the "Business" route sign, U.S. or state numbered route marker and directional arrow, will be furnished by the city.

*b.* The city and county shall erect all signs required on streets and highways within their respective jurisdictions.

*c.* The department of transportation shall erect all signs required within the right-of-way of primary highways and primary highway extensions.

d. The municipality shall maintain all signs at proper position and elevation, and in a clean and legible state.

**131.2(4) Procedures.**

a. A request for the designation of a business route shall be submitted by a city to the appropriate district office.

b. The traffic and safety bureau shall determine if the request is to be approved or denied.

c. The traffic and safety bureau shall designate the signing requirements for establishment of the business route.

**131.2(5) Service level to be maintained.** If either the signs or the streets and highways are not maintained at acceptable levels for traffic service, the department of transportation may require removal of the signs designating a business route.

[ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.3(321) Erection of signs for schools.** This rule establishes requirements and procedures for the erection of signs for schools.

**131.3(1) Requirements.**

a. Signs may be erected for a junior college, college, university or an area community college.

(1) The school shall provide an accredited program of academic study or an approved program of technical or vocational training under the supervision of the state department of education or the state board of regents.

(2) The school shall have a minimum enrollment of 500 full-time students at that school site.

b. Signs may be erected for a public or private elementary, middle, junior high or senior high school.

(1) The school shall provide an accredited program of academic study under the supervision of the state board of education.

(2) Signs shall not be installed on the federal system of interstate highways or at freeway interchanges.

c. The school is not immediately adjacent to a primary highway or a primary highway extension.

d. The school is located on and directly served by the street or highway considered for signing.

**131.3(2) Procedures.**

a. A request for school signing shall be submitted to the appropriate district office.

b. The traffic and safety bureau shall determine if the request is to be approved or denied.

c. Signs shall be furnished, erected and maintained by the department of transportation upon determination that the requirements of subrule 131.3(1) have been satisfied.

[ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.4(321) Erection of camping service signs on interstate highways.** This rule establishes requirements and procedures for the erection of camping service signs.

**131.4(1) Definition.** “All-weather roads” are roads with sufficient surfacing so as to be passable regardless of weather conditions.

**131.4(2) Requirements.**

a. The distance of the camp facility from the nearest off-ramp intersection with the intersected highway or street should not exceed five miles via an all-weather road or street.

b. Campsites should have a minimum of 20 spaces available for camping and parking.

c. The camping area and all facilities shall be available to the public 24 hours a day on a year-round basis. If a camping facility meets the “24 hours a day” condition but is operated on a seasonal basis, camping service signs shall be provided with the condition that the sign be masked (at no cost to the owner) during that part of the year when the facility is not open to the public.

**131.4(3) Procedures.**

a. A request for camping service signs should be made to the appropriate district office.

b. The appropriate district office shall forward Form 810013, “Application for Camping Service Sign, Interstate,” to the requesting camp owner.

c. The camp owner shall complete Form 810013, sign it, and return it to the appropriate district office.

d. The appropriate district office shall review Form 810013 and verify by inspection that the requirements established in subrule 131.4(2) have been met.

e. When the appropriate district office has verified through inspection that the requirements are satisfied, the district traffic technician shall complete and sign Form 810013, signifying approval of the application. A copy of the approved application shall be promptly forwarded to the applicant.

f. Upon approval of Form 810013, the department of transportation shall erect and maintain, at no cost to the camp owner, camping service signs on the interstate highway. (The department of transportation shall also bear the cost of masking camping service signs during the periods that seasonal campsites are closed to the public.)

**131.4(4) Conditions.**

a. The campground must meet applicable state and local standards for health and sanitation. Camping service signs may be removed if the department is notified by the responsible state or local agency that the campground is in violation of these standards.

b. Camping service signs may be removed if the campground is found to be in violation of any other requirement of this rule.

c. Signing shall not be reinstated without proper notification that the violation has been corrected. [ARC 1986C, IAB 5/13/15, effective 6/17/15; ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.5(321) Erection of signs for sanitary landfills.** This rule establishes requirements and procedures for the erection of signs for sanitary landfills.

**131.5(1) Requirements.**

a. The access from the primary highway must be a direct connection to the sanitary landfill;

b. If the access to the sanitary landfill is connected to a secondary road, the county must make a request on Form 740023, "Proposed Directional Signing," to the appropriate district office; and

c. The sanitary landfill site must be operated under a permit issued by the Iowa department of natural resources.

**131.5(2) Procedure.**

a. A request for sanitary landfill signing shall be submitted to the appropriate district office.

b. The county shall be promptly informed of the final disposition of the request.

c. If the request is approved, the department of transportation shall secure, erect and maintain the sanitary landfill sign on the primary highway.

[ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.6(321) Erection of signs for special events.** This rule establishes requirements, procedures and responsibilities for the erection of signs for special events.

**131.6(1) Requirements.**

a. Expected attendance of over 10,000 people per day.

b. Gathering to involve attendance of people on a statewide basis or nationwide basis.

**131.6(2) Procedures.**

a. A request for special event signing shall be submitted to the appropriate district office.

b. The traffic and safety bureau shall determine if the request is to be approved or denied.

c. The traffic and safety bureau shall designate the signing requirements and locations for the signs.

**131.6(3) Responsibilities.**

a. The required signs shall be furnished by the sponsoring organization.

b. The signs shall be placed and removed by the sponsoring organization.

c. The sponsoring organization shall provide for personnel to direct traffic during the duration of the event.

**131.6(4) Duration of placement.** The signs are to be in place only on the day or days of the special event.

[ARC 1986C, IAB 5/13/15, effective 6/17/15; ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.7(321) Erection of signs for organized off-highway camps.** This rule establishes requirements, procedures and responsibilities for the erection of signs for organized off-highway camps.

**131.7(1) Requirements.** The camps shall be permanent and operated by recognized and established civic, religious, and nonprofit charitable organizations.

**131.7(2) Procedures.**

a. A request for signing shall be submitted to the appropriate district office.

b. The traffic and safety bureau shall determine if the request is to be approved or denied.

**131.7(3) Financial responsibility.** The department of transportation shall purchase, install and maintain the signs upon the prepayment by the organization of the cost of purchase, installation and maintenance.

[ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.8(321) Erection of signs for county conservation parks.** This rule establishes requirements, procedures and responsibilities for the erection of signs for county conservation parks.

**131.8(1) Requirements.** The park shall have as its primary purposes outdoor recreation and nature appreciation.

**131.8(2) Procedures.**

a. A request for county conservation park signing shall be submitted on Form 740023, "Proposed Directional Signing," to the appropriate district office.

b. The traffic and safety bureau shall review and make the final determination on the request and promptly inform the county of the determination.

**131.8(3) Responsibilities.**

a. If the request is approved, the traffic and safety bureau shall design the signs and furnish the applicant a scaled drawing of the required signs.

b. The applicant shall furnish to the department of transportation the required signs at a location specified by the department.

c. The department of transportation will erect the signs and provide normal maintenance.

d. If the sign(s) must be replaced for any reason, the applicant shall furnish new sign(s) to the department of transportation.

[ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.9(321) Erection of no parking signs.** This rule establishes procedures and conditions for the erection of no parking signs on rural primary highways.

**131.9(1) Procedures.** Requests for the erection of no parking signs on rural primary highways shall be made by the Iowa state patrol or sheriff to the appropriate district office.

**131.9(2) Conditions.** The signs will be furnished, erected and maintained by the department of transportation; however, they shall be removed if the department determines the parking prohibition is not enforced.

[ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.10(321) Signing for named routes and memorial bridges.** This rule establishes the requirements and procedures for placing special signs along the primary highway for the purpose of designating a primary highway as a memorial highway, a historic trail, or a scenic trail or a bridge on the primary highway as a memorial bridge.

**131.10(1) Definitions.**

"*Historic trail*" means a route located on or near the approximate alignment of a trail on which a person or group traveled while making a journey of regional or national historic significance.

"*Manual on Uniform Traffic Control Devices (MUTCD)*" means the Federal Highway Administration standards on traffic control devices, as adopted in rule 761—130.1(321).

"*Memorial bridge*" means a bridge on the primary highway that has been given a name to commemorate a person, group, place or event of regional or national significance.

"*Memorial highway*" means a primary highway that has been given a name to commemorate a person, group, place or event of regional or national significance.

“*Named route*” means a memorial highway, a historic trail or a scenic trail.

“*Primary highway*,” for the purpose of this rule, does not include an interstate highway.

“*Scenic trail*” means a route, loop or circuit with special scenic or recreational appeal.

**131.10(2) General requirements.**

a. Interstate highways have been designated as the “Dwight D. Eisenhower National System of Interstate and Defense Highways” and are not eligible for naming under these rules. However, bridges on interstate highways may be named.

b. The named route shall be continuous with no breaks at the boundaries of political subdivisions. Each city and county through which a named route passes must provide the department a resolution in support of the route designation. This includes portions of the route off the primary highway system. The memorial bridge shall be located on the primary highway, and the city and county in which the bridge is located must provide a resolution to the department in support of the bridge designation.

c. A memorial highway should normally encompass the entire length of a primary highway within the state. However, it is permissible to name a section of a primary highway if the section is unique or independent by virtue of its design characteristics, such as a freeway, or its geographic location, such as a segment between two junctions. No more than one name shall be used for a bridge or for the same section of a route.

d. Signs designating a named route or memorial bridge shall be furnished and paid for by the applicant including any replacements needed due to sign deterioration or damage. Failure to comply with this requirement may result in removal of all signs for the named route or memorial bridge along the primary highway. The applicant is responsible for providing the department with the applicant’s current contact information. If the department is unable to make contact with the applicant when replacement signs are needed, it may be necessary to remove all signs for the named route or memorial bridge along the primary highway.

e. The applicant shall be responsible for the costs to install the signs, including the posts and hardware.

f. A named route or memorial bridge shall not be given a name which could be considered discriminatory, biased or inappropriate.

**131.10(3) Memorial highway or bridge signing.** Signing for memorial highways or bridges shall comply with the MUTCD as modified by the following:

a. Memorial highway or bridge signing off the primary highway right-of-way:

(1) Preferably, signing for a memorial highway or bridge should neither appear on or along the primary highway nor be placed on bridges or other highway components. Signing is best accomplished by placing memorial plaques in rest areas, scenic overlooks or other appropriate locations off the right-of-way where parking is provided. These plaques shall be located in a manner that will not distract motor vehicle operators.

(2) Departmental approval is not needed for memorial highway or bridge signing placed off the right-of-way at locations not subject to control under Iowa Code chapter 306B or chapter 306C, division II.

b. Memorial highway or bridge signing within the primary highway right-of-way:

(1) If placement of memorial plaques off the right-of-way is not acceptable, the department may approve the installation of memorial highway or bridge signs within the right-of-way provided they are independent of other guide and directional signing and they do not adversely compromise the safety or efficiency of traffic flow.

(2) As determined by the department, a memorial highway or bridge sign within the right-of-way shall be sized based on the size of lettering required for the traffic speed and type of highway being named. The color will be white lettering on brown background, and the design must be approved by the department. If the applicant prefers the sign include a design symbolic of the group or event, instead of the name, then the sign is limited in size to no larger than 24 inches in width and 30 inches in height. The color and design must be approved by the department.

(3) The number of memorial highway signs within the right-of-way shall be limited to one sign at each end of the memorial highway and one sign when entering the corporate limits of each city through

which the memorial highway passes. The number of memorial bridge signs will be limited to one sign for each direction of traffic.

**131.10(4) *Historic trail and scenic trail signing.*** The department may approve the installation of historic trail and scenic trail signing within the primary highway right-of-way. Signing for historic trails and scenic trails shall comply with the MUTCD and the following:

*a.* A sign designating a historic trail or scenic trail shall be no larger than 24 inches in width and 30 inches in height. The colors used shall be limited to white, black, brown, blue or green. The color and design must be approved by the department.

*b.* Signs designating a historic trail or scenic trail may be placed at each end of the trail, when entering the corporate limits of cities through which the trail passes, and at points where the trail direction changes.

*c.* Additional trail signs may be placed between cities along the trail. These signs when facing the same direction of travel shall be spaced at least five miles apart. An exception may be made when the trail direction changes.

*d.* A sign designating a historic trail or scenic trail shall be placed alone on a post.

**131.10(5) *Procedures.***

*a.* To request placement of signs designating a primary highway or bridge as a named route or memorial bridge, the applicant shall submit a formal written request to the appropriate district office.

*b.* The request shall contain the following:

(1) A detailed description of the proposed named route or memorial bridge, including those portions of the route off the primary highway system.

(2) If the request is for a memorial highway or bridge, documentation supporting the significance of the person, group, place or event for which the memorial highway or bridge is named. Any person being honored must have provided extraordinary public service or some exemplary contribution to the public good or outstanding service to the nation, this state or the person's community and have a connection to the community where the highway or bridge is located. The person being honored must be deceased for one year.

(3) If the request is for a historic trail, documentation supporting the historical significance of the trail.

(4) If the request is for a scenic trail, information outlining the features or facilities that are of special scenic or recreational appeal.

(5) A sketch of the sign proposed for designating the named route.

(6) Proposed locations for placement of the signs, including those locations off the primary highway system.

(7) A signed resolution from each city and county through which the named route passes or where the bridge is located, indicating support of the route designation.

*c.* The department shall evaluate the request against the requirements of this rule and notify the requester of approval or denial of the request. Notification of denial shall include the reasons for denial.

*d.* The department shall install approved signs provided by the applicant (see paragraph 131.10(2)“*d*”) and provide routine maintenance when the signs are to be located within the primary highway right-of-way. The applicant shall be responsible for the installation costs for each of the signs.

*e.* The department is not responsible for the installation or maintenance of signs placed off the right-of-way or placed on the city or county highways.

[ARC 1986C, IAB 5/13/15, effective 6/17/15]

**761—131.11(314) *Signing for Iowa medal of honor highway.*** This rule establishes the procedures and requirements for private entities to purchase and pay for the installation of signs designating the Iowa medal of honor highway.

**131.11(1) *Definition.*** “*Iowa medal of honor highway*” means the segment of the highway known as United States Highway 20, as designated as of June 17, 2020, which crosses this state from Sioux City to Dubuque.

**131.11(2) *Requirements.***

*a.* The number of signs within the highway right-of-way shall be limited to one sign at each end of the Iowa medal of honor highway for traffic entering the state and one sign at each entry point of the corporate limits of each city through which the Iowa medal of honor highway passes.

*b.* Each sign shall match the design approved and provided by the department, and the sign materials shall comply with departmental standard specifications as they exist at the time of fabrication. The departmental standard specifications can be found through the department's electronic reference library available on the department's website at [www.iowadot.gov](http://www.iowadot.gov).

*c.* Once signs are installed at one of the approved locations, no additional requests will be accepted for that location. When signs have been installed at all locations identified in paragraph 131.11(2) "a," no further requests will be accepted.

*d.* The applicant may purchase a sign from the department's sign shop or any other private sign shop. If an applicant chooses to obtain a sign from a private sign shop, the department will furnish the sign design and approve the construction prior to purchase. The department will also inspect the sign as stated in subrule 131.11(5).

*e.* Signs designating the Iowa medal of honor highway shall be furnished and paid for by the applicants, including any replacements needed due to sign deterioration or damage. The applicant is responsible for providing the traffic and safety bureau with the applicant's current contact information so the applicant can be contacted when a replacement sign is needed. Failure to comply with this requirement may result in removal of all signs the applicant purchased. This would allow a new private entity to sponsor the signing.

*f.* The applicant shall be responsible for the cost to install the sign, including the posts and hardware. Payment to the department must be received prior to the installation of the sign.

*g.* The department shall install the sign.

**131.11(3) Procedures.**

*a.* A written request to purchase or install a sign shall be submitted to the traffic and safety bureau.

*b.* The request shall contain the following:

- (1) The applicant's name and contact information.
- (2) A description of the location where the sign is to be installed.
- (3) If the sign will be purchased from the department or a private sign shop.

**131.11(4) Approval.** If the request complies with this rule, the traffic and safety bureau shall respond to the applicant with approval of the proposed location or modified location and an estimate of the costs for the sign and installation. Following inspection of the sign in compliance with subrule 131.11(5) and receipt of payment, the department shall install the sign.

**131.11(5) Inspection.** If a sign is not purchased from the department sign shop, the applicant shall deliver the sign to the department sign shop for inspection. Upon receipt of the sign, the department shall inspect the sign for compliance with the approved sign design and departmental specifications and notify the applicant.

[ARC 5426C, IAB 2/10/21, effective 3/17/21]

**761—131.12 to 131.14** Reserved.

**761—131.15(321) Information and address.** Information regarding the signing addressed in this chapter is available from: Traffic and Safety Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010. Submissions to the traffic and safety bureau shall also be sent or delivered to this address.

[ARC 5426C, IAB 2/10/21, effective 3/17/21]

These rules are intended to implement Iowa Code sections 314.31, 321.252 and 321.253.

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## PRIMARY ROAD EXTENSIONS

## CHAPTER 150

## IMPROVEMENTS AND MAINTENANCE ON PRIMARY ROAD EXTENSIONS

[Prior to 6/3/87, Transportation Department[820]—(06.L) Ch 1]

**761—150.1(306) Definitions.**

“*Access control limits*” means the area within the primary highway right-of-way limits, including right-of-way lines extended across side streets and roads. The term includes areas on side streets and roads where the department has acquired access control rights in accordance with 761—Chapter 112.

“*City*” means a municipal corporation as defined in Iowa Code section 362.2.

“*Encroachment*” means an item which is supported or located on the highway right-of-way or which overhangs into the airspace of the highway right-of-way.

“*Freeway*” means a primary highway constructed with Priority I access control. For the purpose of highway lighting, “*freeway*” means a primary highway constructed with Priority I access control for a length of five miles or greater.

“*MUTCD*” means the “Manual on Uniform Traffic Control Devices,” as adopted in 761—Chapter 130.

“*Nonfreeway primary highway*” means a primary highway that is not a freeway.

“*Obstruction*” means the same as defined in Iowa Code section 318.1.

“*Right-of-way*” means the land for any public road, street or highway, including the entire area between the property lines.

“*Urban-state traffic engineering program*” or “*U-STEP*” refers to a department program that is intended for use by any Iowa city in order to solve traffic operations and safety problems on primary roads in Iowa cities as documented in the department’s “Guide to Transportation Funding Programs.”

“*Utility*” means the same as defined in Iowa Code section 306A.13.

This rule is intended to implement Iowa Code sections 306.2, 306.3, 306A.13, 318.1 and 362.2.  
[ARC 3501C, IAB 12/6/17, effective 1/10/18]

**761—150.2(306) Improvements and maintenance on extensions of freeways.**

**150.2(1) Construction.** Except as otherwise provided, the department shall be responsible for all right-of-way and construction costs associated with the construction of freeway extensions.

a. The city shall be responsible for providing, without cost to the department, all necessary rights-of-way that involve dedicated streets or alleys.

b. The city may be responsible for providing, without cost to the department, all necessary rights-of-way that involve other city-owned lands, except parklands, subject to the condition that the department may reimburse the city for the functional replacement value of improved property and advanced purchases negotiated by the city for project purposes.

c. Outside the access control limits, the department shall be responsible for the costs of construction of longitudinal and outlet storm sewers made necessary by highway construction in the proportion that the street right-of-way of the primary road extension bears to the total drainage area to be served by the proposed sewers. The city shall be responsible for the remaining portion of storm-sewer costs not paid for by the department.

d. The department shall be responsible for all storm sewer-related costs within the access control limits.

**150.2(2) Maintenance.** The department shall enter into an agreement with a city regarding the maintenance of primary roads within the corporate city limits. This is intended to include corporate line roads, when appropriate. Unless otherwise mutually agreed to and specified in the agreement, the maintenance of freeway extensions within the corporate city limits, including corporate line roads, shall be as follows:

a. The department shall be responsible for all maintenance costs on the through roadway, the on and off ramps, and the roadside features from right-of-way line to right-of-way line.

b. Where city streets cross the freeway, the department shall be responsible for:

- (1) Roadside maintenance within the limits of the freeway fence.
- (2) Surface drainage of the right-of-way.
- (3) Traffic signs and pavement markings required for freeway operation.
- (4) Guardrail at piers and bridge approaches.
- (5) Expansion relief joints in approach pavement and leveling of bridge approach panel(s).
- (6) All maintenance of bridges including deck repair, structural repair, berm slope protection, painting, and inspection, except as noted in paragraph "c" of this subrule.
  - c. Where city streets cross the freeway, the city shall be responsible for:
    - (1) All roadside maintenance outside the freeway fence.
    - (2) All pavement, subgrade and shoulder maintenance on the cross street except expansion relief joints and bridge approach panel leveling.
    - (3) All traffic lane markings on the cross street.
    - (4) Snow removal on the cross street including bridges over the freeway.
    - (5) Cleaning and sweeping bridge decks on streets crossing over the freeway.
  - d. The city shall be responsible for maintenance and repair of pedestrian overpasses and underpasses including snow removal, painting, lighting and structural repairs.
  - e. Should local service roads or streets be constructed as a part of a project, upon completion they shall become a part of the city street system. The department shall not be responsible for the maintenance of these roads or streets and corresponding drainage structures.

**150.2(3) Lighting.**

- a. The department shall be responsible for the cost of installation of lighting on the main-traveled-way lanes and the on and off ramps including the terminals with cross streets when the department determines that lighting is required under established warrants.
- b. The department shall be responsible for the energy and maintenance costs of lighting on the main-traveled-way lanes.
- c. The department shall be responsible for the energy and maintenance costs of lighting through interchange areas and ramps at interchanges between freeways which do not provide service to local streets.
- d. The department shall be responsible for the energy and maintenance costs of lighting in interchange areas at interchanges between freeways and primary roads which are on corporate lines.
- e. At interchanges with city cross streets, the department shall be responsible for the energy and maintenance costs of lighting on the main-traveled-way lanes, on and off ramps, ramp terminals, and, when the department determines full interchange lighting is required, the cross street between the outermost ramp terminals.
- f. The department shall not be responsible for the installation, energy, and maintenance costs of any lighting on cross streets in advance of interchanges and between the outermost ramp terminals at interchanges where the department determines partial interchange lighting or no lighting is required.
- g. The department shall not be responsible for the installation, energy and maintenance costs of any lighting on pedestrian overpasses, pedestrian underpasses, bicycle overpasses or bicycle underpasses. The city may elect to provide lighting at its own expense.
- h. Warrants for the lighting of freeways shall be according to the 2005 "AASHTO Roadway Lighting Design Guide."

**150.2(4) Traffic signals at ramp terminals with cross streets.**

- a. All traffic signal installations shall meet the standards and warrants established in the MUTCD.
- b. On projects initiated by the department, the department may install, at no cost to the city, traffic signals warranted when replacing existing pavement or adding new lanes. In conjunction with these projects, the department may also participate in the cost of signals that are for pedestrian use only. If the department participates, the department's share of the installation costs shall be based on the current U-STEP cost apportionment.
- c. When new pavement construction or additional lanes are not involved, the department may participate in the installation costs of new and modernized traffic signals or signals that are for pedestrian use only. If the department participates, the department's share of the installation costs shall be based on

the current U-STEP cost apportionment; the city shall prepare plans, award the contract, supervise the installation, and be responsible for the remaining installation costs.

*d.* Modifications made to the traffic signal system to coordinate it with other city signal systems (not on the primary road extension system) shall be the sole financial responsibility of the city.

*e.* The department shall not assume ownership and shall not be responsible for the energy and maintenance costs involved in the operation of traffic signals.

*f.* Signal phasing, initial and future, as well as timing and coordination between intersections shall be coordinated between the department and the city.

This rule is intended to implement Iowa Code sections 306.4, 306.42, 313.4, 313.5, 313.21 to 313.24, 313.27, 313.36, 314.5 and 314.6 and chapter 306A.

[ARC 3501C, IAB 12/6/17, effective 1/10/18; ARC 5427C, IAB 2/10/21, effective 3/17/21]

## **761—150.3(306) Improvements and maintenance on extensions of nonfreeway primary highways.**

### **150.3(1) Construction.**

*a.* The department shall be responsible for all right-of-way and construction costs to construct nonfreeway primary highway extensions to the minimum design criteria as established by the department. Construction improvement costs beyond minimum design criteria shall be the responsibility of the city, as specified in the project agreement. Minimum design criteria shall be in accordance with “A Policy on Geometric Design of Highways and Streets, 2018” (Seventh Edition AASHTO Green Book).

*b.* The city shall be responsible for providing, without cost to the department, all necessary rights-of-way that involve dedicated streets or alleys.

*c.* The city may be responsible for providing, without cost to the department, all necessary rights-of-way that involve other city-owned lands, except parklands, subject to the condition that the department may reimburse the city for the functional replacement value of improved property and advanced purchases negotiated by the city for project purposes.

*d.* The city shall take all necessary legal action to discontinue and prohibit any past or present use of project rights-of-way for private purposes. The city shall prevent any future encroachment or obstruction within the limits of project rights-of-way.

*e.* The department shall be responsible for the costs of construction of longitudinal and outlet storm sewers made necessary by highway construction and construction of local service roads developed as a part of the construction or reconstruction of the through traffic lanes in the proportion that the right-of-way of the primary road extension bears to the total drainage area to be served by the proposed sewers. The city shall be responsible for the remaining portion of storm-sewer costs not paid for by the department.

*f.* Unless otherwise mutually agreed to and specified in the project agreement, the department shall be responsible for the cost of acquiring rights-of-way and construction of local service roads developed as a part of the construction or reconstruction of the through traffic lanes.

**150.3(2) Maintenance.** The department shall enter into an agreement with a city regarding the maintenance of primary roads within the corporate city limits. This is intended to include corporate line roads, when appropriate. Unless otherwise mutually agreed to and specified in the agreement, the maintenance of nonfreeway primary highway extensions within the corporate city limits, including corporate line roads, shall be as follows:

*a.* On primary roads constructed with a curbed cross section, the department shall be responsible for:

(1) Maintenance and repairs to pavement and subgrade from face of curb to face of curb exclusive of parking lanes, culverts, intakes, manholes, public or private utilities, sanitary sewers and storm sewers.

(2) Primary road signing for moving traffic as set out in subrule 150.4(1), pavement markings for traffic lanes, guardrail and stop signs at intersecting streets.

(3) Surface drainage only, within the limits of pavement maintenance.

(4) Plowing of snow from the traffic lanes of pavement and bridges and treatment of traffic lanes with abrasives and chemicals.

(5) Inspection, painting and structural maintenance of bridges as defined in Iowa Code section 309.1.

*b.* On primary roads constructed with a rural cross section (no curb), the department shall be responsible for all maintenance, except tree removal, sidewalks, retaining walls and repairs due to utility construction and maintenance shall be the city's responsibility.

*c.* On primary roads constructed with a curbed cross section, the city shall be responsible for:

(1) Maintenance and repairs to pavement in parking lanes, intersections beyond the limits of department pavement maintenance, curbs used to contain drainage, and repairs to all pavement due to utility construction, maintenance and repair.

(2) Painting of parking stalls, stop lines and crosswalks, and the installation and maintenance of flashing lights. Pavement markings shall conform to the MUTCD.

(3) Maintenance of all storm sewers, manholes, intakes, catch basins and culverts used for collection and disposal of surface drainage.

(4) Removal of snow windrowed by departmental plowing operations, removal of snow and ice from all areas outside the traffic lanes, loading or hauling of snow which the city considers necessary and removal of snow and ice from sidewalks on bridges used for pedestrian traffic.

(5) Maintenance of sidewalks, retaining walls and all areas between curb and right-of-way line.

(6) Cleaning, sweeping and washing of streets.

(7) Maintenance and repair of pedestrian overpasses and underpasses including snow removal, painting and structural repairs.

(8) Maintenance and repair of bicycle overpasses and underpasses including snow removal, painting and structural repairs.

*d.* The city shall comply with the access control policy of the department as adopted in 761—Chapter 112 and obtain prior approval from the department for any changes to existing entrances or for the construction of new entrances.

*e.* Drainage district assessments levied against the primary road within the corporate limits of the city shall be shared equally by the department and the city.

*f.* Should local service roads or streets be constructed as a part of a project, upon completion they shall become a part of the city street system. The department shall not be responsible for the maintenance of these roads or streets and corresponding drainage structures.

**150.3(3) *Lighting.***

*a.* The department shall not be responsible for the installation, energy, and maintenance costs of lighting on extensions of nonfreeway primary highways. The city may elect to provide lighting at its own expense. However:

(1) For cities with a population of 5,000 or less, the department may elect to install interchange lighting and to be responsible for or to participate in the energy and maintenance costs of this lighting.

(2) On a new construction project that results in a predominately fully controlled access highway, but incorporates some nonfreeway segments, the department may elect to participate in the installation of lighting at conflict points if the city agrees to be responsible for the energy and maintenance costs of this lighting.

*b.* At corporate line primary road junctions, the lighting shall be installed where necessary by the department in accordance with department warrants. The department shall be responsible for the installation costs. Unless otherwise agreed, the energy and maintenance costs shall be shared by the city and department in proportion to the number of luminaires in each jurisdiction as established by the corporate line. When and if the corporate line is extended to include any part of the lighting installation or a greater proportion of luminaires, the proportionate costs for maintenance and energy shall be redetermined on the basis of the number of luminaires in each jurisdiction as established by the new location of the corporate line.

**150.3(4) *Traffic signals.***

*a.* All traffic signal installations shall meet the standards and warrants established in the MUTCD.

*b.* On projects initiated by the department, the department may install, at no cost to the city, traffic signals warranted when replacing existing pavement or adding new lanes. In conjunction with these

projects, the department may also participate in the cost of signals that are for pedestrian use only. If the department participates, the department's share of the installation costs shall be based on the current U-STEP cost apportionment.

c. When new pavement construction or additional lanes are not involved, the department may participate in the installation costs of new and modernized traffic signals or signals that are for pedestrian use only. If the department participates, the department's share of the installation costs shall be based on the current U-STEP cost apportionment; the city shall prepare plans, award the contract, supervise the installation, and be responsible for the remaining installation costs.

d. Modifications made to the traffic signal system to coordinate it with other city signal systems (not on the primary road extension system) shall be the sole financial responsibility of the city.

e. The department shall not participate in the cost of signals for commercial use only.

f. The department shall not participate in the signalization of primary road stub routes which terminate within the city.

g. The department shall not assume ownership and shall not be responsible for any energy or maintenance costs for traffic signals.

h. Signal phasing, initial and future, as well as timing and coordination between intersections shall be coordinated between the department and the city.

**150.3(5) *Overdimensional and overweight vehicles.*** The city shall comply with all current statutes, rules and regulations pertaining to overdimensional and overweight vehicles using primary roads when issuing special permits for overdimensional and overweight vehicles.

This rule is intended to implement Iowa Code sections 306.4, 306.42, 313.5, 313.21 to 313.24, 313.27, 313.36, 314.5, 314.6 and 321E.3 and chapter 306A.

[ARC 3501C, IAB 12/6/17, effective 1/10/18; ARC 5427C, IAB 2/10/21, effective 3/17/21]

#### **761—150.4(306) General requirements for primary road extensions.**

##### **150.4(1) *Signing.***

a. The department shall be responsible for permanent traffic control signing on primary road extensions.

b. The department shall not be responsible for construction and maintenance work zone signing unless the work is being done by the department.

c. The department shall not be responsible for street name signs, any regulatory parking signs which denote special regulations as may be determined by the city in cooperation with the department, and those signs which regulate parking as to time, hours and days of the week.

d. The department shall not be responsible for signs facing traffic on primary road extensions which regulate traffic movements on city cross streets (one-way traffic).

e. "Business District" signs on primary road extensions may be permitted upon application by the city to the department.

f. All signing within the right-of-way shall conform to the MUTCD.

##### **150.4(2) *Encroachments and obstructions.***

a. The city shall remove any existing obstructions within the highway right-of-way and prevent any future obstructions from occurring within the highway right-of-way, in a manner consistent with Iowa Code chapter 318.

b. The city shall remove any existing encroachments and prevent any future encroachments from occurring within the highway right-of-way, except those authorized or permitted by the highway authority. Under no circumstances shall an overhanging sign or awning be allowed within two feet of the inside edge of the curb (also known as the face of the curb, which is that part of the curb that is next to traffic) or within two feet of the edge of the pavement in the absence of a curb. Any encroachments authorized or permitted by the highway authority shall be in accordance with Iowa Code chapter 318.

##### **150.4(3) *Pedestrian, equestrian, and bicycle routes (sidewalks).***

a. The department shall remove and replace portions of existing routes as required by construction.

b. The department will consider the impacts to pedestrian accommodation at all stages of the project development process and encourage pedestrian accommodation efforts when pedestrian

accommodation is impacted by highway construction. The cost of pedestrian accommodation made at the time of the highway improvement may be considered an additional roadway construction cost. Providing pedestrian accommodation independent of a highway construction project may be considered with construction funding obtained from local jurisdictions or other federal and non-road use tax state sources.

*c.* If a project is initiated by the department, the department shall fund 100 percent of all curb ramps, turning spaces, transitions, sidewalks, curb drops and pedestrian signals within the right-of-way of primary road extensions to meet the requirements of the Americans with Disabilities Act if such improvements are in the project.

*d.* If a project is initiated by a local jurisdiction, the department may participate by funding 55 percent of the cost of constructing curb ramps, turning spaces, transitions, sidewalks, curb drops and pedestrian signals on existing sidewalks within the right-of-way of primary road extensions to meet the requirements of the Americans with Disabilities Act if such improvements are in the project. However, departmental participation shall not exceed \$250,000 per year for any one local jurisdiction and \$5 million per year in total.

**150.4(4)** *Overpasses and underpasses for pedestrian, equestrian, and bicycle routes.*

*a.* During initial construction of freeways and other relocated primary road extensions and when user-volumes and topographic conditions warrant the construction of a separation, the cost shall be shared between the department and the city on the basis of the current U-STEP cost apportionment.

*b.* The department may participate in a city-initiated separation as an unscheduled project.

**150.4(5)** *Utility relocation and removal.*

*a.* The city shall relocate or cause to be relocated, without cost to the department, all city-owned utilities necessary for construction when these utilities are within the existing street or alley right-of-way. The department shall reimburse the owner of a utility which is located on private right-of-way for the costs of relocation or removal, including the costs of installation in a new location.

*b.* The city shall comply with the utility accommodation policy of the department, as adopted in 761—Chapter 115.

**150.4(6)** *Project concept statements and predesign project agreements for proposed construction projects.*

*a.* As early as possible after an urban project is included in the department's "Five-Year Iowa Transportation Improvement Program," a concept statement for the project shall be developed and shall be reviewed with the officials of the city prior to the public hearing.

*b.* During the design process, a predesign project agreement may be submitted to city officials for their approval. It shall include:

- (1) A preliminary description of the project,
- (2) The general concepts of the project,
- (3) Responsibilities for right-of-way acquisition, storm sewer costs and utility adjustment costs,
- (4) The parking and access control restrictions to be applied to the project, and
- (5) Financial participation above minimum standards.

**150.4(7)** *Preconstruction project agreements for proposed construction projects.*

*a.* The department shall maintain a close liaison with the city during the development of the project plan so that all parties will be fully informed of the details involved in the proposed improvement.

*b.* When the plan is sufficiently complete to provide typical cross sections, plan and profile drawings and incidental details, the department shall submit a preconstruction project agreement, which shall include known design data, to city officials for their approval. Terms for reimbursement to the state and local financial participation shall be stated in this agreement.

*c.* Modifications to this agreement necessitated by design changes encountered during construction shall be made by extra work order agreed to in writing by the city, the contractor, and the department.

This rule is intended to implement Iowa Code sections 306.4, 313.21 to 313.24, 313.27, 313.36, 314.5 and 314.6 and chapters 306A and 318.

[ARC 0478C, IAB 12/12/12, effective 1/16/13; ARC 3501C, IAB 12/6/17, effective 1/10/18]

**761—150.5(307) Special circumstances.**

**150.5(1) *Waivers.*** The director of transportation may, in response to a written petition, waive provisions of this chapter in accordance with 761—Chapter 11. The written petition must contain the information as required in 761—subrule 11.5(2) and shall be submitted to the Rules Administrator, Strategic Communications and Policy Bureau, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; or by email to the rules administrator’s email address listed on the department’s website at [iowadot.gov/administrativerules](http://iowadot.gov/administrativerules).

**150.5(2) *Waivers involving interstate highways.*** The director of transportation shall not waive these rules if the request involves the interstate highway system, including its ramps, without the approval of the Federal Highway Administration.

This rule is intended to implement Iowa Code sections 17A.9A and 307.12.

[ARC 3501C, IAB 12/6/17, effective 1/10/18; ARC 5427C, IAB 2/10/21, effective 3/17/21]

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CHAPTER 511  
SPECIAL PERMITS FOR OPERATION AND MOVEMENT OF  
VEHICLES AND LOADS OF EXCESS SIZE AND WEIGHT

[Appeared as Ch 2, Highway Commission, 1973 IDR; amended in July 1974 and January and July 1975 Supplements]

[Previously numbered as (07,E) Ch 12, transferred at the request of the department on 10/8/75]

[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 2]

**761—511.1(321E) Definitions.** As used in this chapter, unless the context otherwise requires:

“*Compacted rubbish vehicle*” means any vehicle hauling rubbish that has been mechanically compacted with a hydraulic, electric, or air-operated ram.

“*Department*” means the Iowa department of transportation.

“*Dimensions*” or “*size*” means length, width or height limits.

“*Indivisible load*” means any load or vehicle exceeding applicable length or weight limits which, if separated into smaller loads or vehicles, would:

1. Compromise the intended use of the vehicle, i.e., make it unable to perform the function for which it was intended;
2. Destroy the value of the load or vehicle, i.e., make it unusable for its intended purpose; or
3. Require more than eight work hours to dismantle using appropriate equipment. The applicant for an indivisible load permit has the burden of proof as to the number of work hours required to dismantle the load.

“*Overdimensional*” or “*oversize*” means the exceeding of statutory length, width or height limits.

“*Permit*” means a permit issued under Iowa Code chapter 321E for the movement of an overdimensional or overweight vehicle, combination of vehicles, or vehicle with load. The term includes any additions or supplements thereto issued by the permit-issuing authority.

“*Permit-issuing authority*” means the:

1. Department’s vehicle and motor carrier services bureau for permits for movement on the primary road system.
2. Authority responsible for the maintenance of a nonprimary system of highways or streets for permits for movement on that system. However, the vehicle and motor carrier services bureau may issue single-trip permits on primary road extensions in cities in conjunction with movement on the rural primary road system.

“*Primary roads*” or “*primary road system*” is defined in Iowa Code section 306.3. The primary road system includes the interstate road system.

“*Raw forest products*” means the same as defined in Iowa Code section 321E.26.

“*Rubbish*” means any unwanted or useless material that has no commercial or practical value or use and that would normally be discarded.

“*Special or emergency situation*” means one or more of the following:

1. Circumstances where the movement is necessary to cooperate with cities, counties, other state agencies or other states in response to a national or other disaster.
2. Circumstances where the movement is necessary to cooperate with national defense officials.
3. Circumstances where the movement is necessary to cooperate with public or private utilities in order to maintain their public services.
4. Circumstances where the movement is essential to ensure safety and protection of any person or property due to an event such as, but not limited to, pollution of natural resources, a potential fire or an explosion.
5. Circumstances where weather or transportation problems create an undue hardship for citizens of the state of Iowa.
6. Circumstances where the movement involves emergency-type vehicles.
7. Uncommon or extraordinary circumstances where the movement is essential to the existence of an Iowa business and the move may be accomplished without causing undue hazards to the safety of the traveling public or undue damage to private or public property.
8. Other unique circumstances that warrant the issuance of a permit as determined by the permit-issuing authority.

“Statutory” when used with size or weight limits refers to those limits found in Iowa Code chapter 321.

This rule is intended to implement Iowa Code sections 321E.9, 321E.15, 321E.26, 321E.29, 321E.30 and 321E.34.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

#### **761—511.2(321E) Location and general information.**

**511.2(1)** Applications, forms, instructions and restrictions are available on the department’s website at [www.iowadot.gov](http://www.iowadot.gov) and by mail from the Vehicle and Motor Carrier Services Bureau, Iowa Department of Transportation, P.O. Box 10382, Des Moines, Iowa 50306-0382; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)237-3264; or by facsimile at (515)237-3257. Permits may be obtained electronically upon making application to the vehicle and motor carrier services bureau.

**511.2(2)** No overdimensional or overweight vehicle, combination of vehicles, or vehicle with load shall be moved on the highways of this state without permit except as provided in Iowa Code section 321.453.

**511.2(3)** Rescinded IAB 2/7/01, effective 3/14/01.

**511.2(4)** Except as provided in rule 761—511.15(321,321E), permits may be issued only for the transporting of a single article which exceeds statutory size or weight limits or both, and which cannot reasonably be divided or reduced to statutory size and weight limits. However, permits may be issued for the transporting of property consisting of more than one article when:

- a. The statutory weight limits are not exceeded,
- b. One of the articles exceeds the statutory size limits, and
- c. The inclusion of other articles does not cause the statutory size limits to be exceeded by an additional amount.

**511.2(5)** Nothing in the permit shall be construed as waiving any load limits which have been or which might be established on any bridge or any road which is posted with embargo signs, unless specifically stated on the permit.

**511.2(6)** The state of Iowa, the department, and any other permit-issuing authority assume no responsibility for the property of the permit holder. Permit holders shall hold permit-issuing authorities harmless of any damages that may be sustained by the traveling public, adjacent property owners or the highways of this state on account of movements made under permit.

This rule is intended to implement Iowa Code sections 17A.3 and 321E.2.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20; ARC 5428C, IAB 2/10/21, effective 3/17/21]

#### **761—511.3(321E) Movement under permit.**

**511.3(1)** During the movement of a vehicle or object under permit, the permit holder shall comply with the terms and conditions of the permit and shall take all reasonable precautions to protect and safeguard the lives and property of the traveling public and adjacent property owners.

**511.3(2)** Movement shall be made only when roads are clear of ice and snow and visibility is at least one-quarter mile. Snow removal equipment operating under permit is exempt from this restriction while snow removal operations are conducted. EXCEPTION: Nothing in this subrule shall be construed to mean that the movement of a compacted rubbish vehicle permitted under rule 761—511.11(321E) shall be subject to this restriction.

**511.3(3)** Movement shall be permitted only during the hours from one-half hour before sunrise to one-half hour after sunset unless it is established by the permit-issuing authority that the movement can be better accomplished at another period of time because of traffic volume conditions.

**511.3(4)** Except as provided in Iowa Code section 321.457, no movement shall be permitted on the holidays of Memorial Day, Independence Day and Labor Day, after 12 noon on days preceding these holidays and holiday weekends, during holiday weekends, or during special events when abnormally high traffic volumes can be expected. A holiday weekend occurs when the holiday falls on Friday, Saturday, Sunday or Monday. No movement shall be permitted until one-half hour before sunrise on the day after the holiday or holiday weekend.

**511.3(5)** Continuous moves. Vehicles and loads may travel by permit between one-half hour after sunset and one-half hour before sunrise if, in addition to the general provisions and general requirements specified by the permit, the following conditions are met.

- a. Dimensions shall not exceed:
  - (1) Width. 11 feet.
  - (2) Height. 14 feet, 6 inches.
  - (3) Length. 100 feet.
  - (4) Weight. Legal axle limits.
- b. Travel must be on roadways with a minimum width of 22 feet and minimum lane width of 11 feet.
- c. Safety lighting shall be provided at the widest part of a load. The lamps may be placed at the outer ends of the load itself or on appurtenances which are equal in width to the widest part of the load and positioned at both the extreme front and rear of the vehicle or trailer as follows:
  - (1) One lighted red lamp on each side at the rear of the load.
  - (2) One lighted yellow or amber lamp on each side at the front of the load.

This rule is intended to implement Iowa Code sections 321E.2 and 321E.11.  
 [ARC 3193C, IAB 7/5/17, effective 8/9/17]

**761—511.4(321E) Permits.** Permits issued shall be in writing or in electronic format and may be either single-trip, multitrip, annual, annual oversize/overweight, annual raw forest products, compacted rubbish or all-systems permits.

**511.4(1) Methods of issuance.**

- a. Permits for movement on the primary road system may be obtained in person, by facsimile, online, or by mail at the address in subrule 511.2(1).
- b. Reserved.

**511.4(2) Forms.**

- a. Applications for permits for movement on the primary road system shall be made online or in the form and manner prescribed by the department.
- b. Any applications to other permit-issuing authorities made upon department forms shall be sufficient and accepted as properly made by these authorities.
- c. Subject to the preceding paragraph, permit-issuing authorities may adopt, amend or modify these forms provided that the amended or modified forms adequately identify the applicant, the hauling vehicle and load, the manner and extent that the vehicle with load exceeds the statutory size and weight limits, the route, and the authorization of the issuing authority. However, the load for a multitrip permit does not have to be identified but the vehicle and load cannot exceed either the weight per axle or the total weight identified on the multitrip permit. Axle spacings cannot change.

**511.4(3) Validity.**

- a. Annual, annual oversize/overweight, annual raw forest products, compacted rubbish, and all-systems permits shall expire one year from the date of issuance.
- b. A single-trip permit shall be effective for five days.
- c. The validity of a multitrip permit shall not exceed 60 calendar days.

**511.4(4) Duplicate permit.** If a permit is lost or destroyed before it has expired, a duplicate permit may be issued at the discretion of the permit-issuing authority. The expiration date on the duplicate permit shall be the same as on the original permit.

This rule is intended to implement Iowa Code sections 321E.2 and 321E.3.  
 [ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20; ARC 5428C, IAB 2/10/21, effective 3/17/21]

**761—511.5(321,321E) Fees and charges.**

**511.5(1) Annual oversize permit.** A fee of \$50 shall be charged for each annual permit issued pursuant to Iowa Code section 321E.8, payable prior to the issuance of the permit. Carriers purchasing annual permits in advance of use cannot return unused permits for refunds.

**511.5(2)** *Special or emergency oversize permit for certain divisible loads.* A fee of \$25 may be charged for each single-trip permit issued pursuant to Iowa Code section 321E.29, payable prior to the issuance of the permit.

**511.5(3)** *Annual raw forest products permit.* A fee of \$175 shall be charged for each annual permit issued pursuant to Iowa Code section 321E.26 for divisible loads of raw forest products, payable prior to the issuance of the permit.

**511.5(4)** *Annual oversize/overweight permit.* A fee of \$400 shall be charged for each annual oversize/overweight permit, payable prior to the issuance of the permit. Transfer of current annual oversize/overweight permit to a replacement vehicle may be allowed when the original vehicle has been damaged in an accident, junked or sold.

**511.5(5)** *All-systems permit.* A fee of \$160 shall be charged for each annual all-systems permit, payable prior to the issuance of the permit.

**511.5(6)** *Bridge-exempt permit.* A fee of \$25 shall be charged for each bridge-exempt permit issued pursuant to Iowa Code section 321E.7, payable prior to the issuance of the permit.

**511.5(7)** *Multitrip permit.* A fee of \$200 shall be charged for each multitrip permit, payable prior to the issuance of the permit.

**511.5(8)** *Raw milk permit.* A fee of \$25 shall be charged for each raw milk permit issued pursuant to Iowa Code section 321E.29A, payable prior to the issuance of the permit.

**511.5(9)** *Single-trip permit.* A fee of \$35 shall be charged for each single-trip permit, payable prior to the issuance of the permit.

**511.5(10)** *Special alternative energy multitrip permit.* A fee of \$600 shall be charged for each special alternative energy multitrip permit issued pursuant to Iowa Code section 321E.9B, payable prior to the issuance of the permit.

**511.5(11)** *Compacted rubbish permit.* A fee of \$100 shall be charged for each compacted rubbish permit, payable prior to the issuance of the permit.

**511.5(12)** *Duplicate permit.* A fee of \$2 shall be charged for each duplicate permit, payable prior to the issuance of the permit.

**511.5(13)** *Registration fee.* A registration fee shall be charged for vehicles transporting buildings, except mobile homes and factory-built structures, on a single-trip basis. The vehicle shall be registered for the combined gross weight of the vehicle and load. The fee shall be 5 cents per ton exceeding the weight registered under Iowa Code section 321.122 per mile of travel and shall be payable prior to the issuance of the permit. Fees shall not be prorated for fractions of miles.

**511.5(14)** *Fair and reasonable costs.* Permit-issuing authorities may charge any permit applicant:

*a.* A fair and reasonable cost for the removal and replacement of natural obstructions or official signs and signals.

*b.* A fair and reasonable cost for measures necessary to avoid damage to public property including structures and bridges.

**511.5(15)** *Methods of payment.* Fees and costs required under this chapter shall be paid in the form and manner prescribed by the department.

This rule is intended to implement Iowa Code sections 321.12, 321.122, 321E.14, 321E.29, 321E.29A and 321E.30.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20; ARC 5428C, IAB 2/10/21, effective 3/17/21]

## **761—511.6(321E) Insurance and bonds.**

### **511.6(1) Insurance.**

*a.* Public liability insurance in the amounts of \$100,000 bodily injury each person, \$200,000 bodily injury each occurrence, and \$50,000 property damage with an expiration date to cover the tenure of the annual, annual oversize/overweight, annual raw forest products, all-systems, multitrip or single-trip permit shall be required. In lieu of filing with the permit-issuing authority, a copy of the current certificate of public liability insurance in these amounts shall be carried in the vehicle for which the permit has been issued. Proof of liability insurance may be either in writing or in electronic format.

b. Notwithstanding paragraph “a” of this subrule, a carrier may act as a self-insurer if an application for self-insurance is filed with and approved by the department.

**511.6(2) Bond.**

a. The permit-issuing authority may require the applicant to file a bond, certified check or other assurance in an amount sufficient to cover the reasonably anticipated cost of damage or loss to private property, either real or personal, likely to be caused by or arising out of the movement of the vehicle and load or to ensure compliance with permit provisions.

b. The amount in the preceding paragraph may be reduced either in whole or in part by the applicant’s submission to the permit-issuing authority of written permission from an affected third party stating in substance that the third party either owns or has the right of exclusive possession and control over the affected property, does by the party’s signature consent to the move and that the applicant has in hand paid or secured the payment of the anticipated cost of loss or damage to the party’s property.

This rule is intended to implement Iowa Code section 321E.13.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

**761—511.7(321,321E) Annual permits.** Annual permits are issued for indivisible vehicles or indivisible loads for travel when the dimensions of the vehicle or load exceed statutory limits but the weight is within statutory limits. Routing is subject to embargoed bridges and roads and posted speed limits. The owner or operator shall select a route using the vertical clearance map and road construction and travel restrictions map provided by the department. Route, detour and road embargo information may be found online at [www.511ia.org](http://www.511ia.org). Annual permits are issued for the following:

**511.7(1)** Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 12 feet 5 inches including appurtenances.

b. *Length.* 120 feet 0 inches overall.

c. *Height.* 13 feet 10 inches.

d. *Weight.* See rule 761—511.14(321,321E).

e. *Distance.* Movement is allowed for unlimited distance; routing through the vehicle and motor carrier services bureau is not required.

**511.7(2)** Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 14 feet 6 inches.

b. *Length.* 120 feet 0 inches overall.

c. *Height.* 15 feet 5 inches.

d. *Weight.* See rule 761—511.14(321,321E).

e. *Distance.* Movement is restricted to 50 miles unless trip routes are obtained from the vehicle and motor carrier services bureau or the route continues on at least four-lane roads. Trip routes are valid for five days.

**511.7(3)** Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 16 feet 0 inches.

b. *Length.* 120 feet 0 inches.

c. *Height.* 15 feet 5 inches.

d. *Weight.* See rule 761—511.14(321,321E).

e. *Distance.* Trip routes must be obtained from the vehicle and motor carrier services bureau.

**511.7(4)** Rescinded IAB 1/23/02, effective 2/27/02.

**511.7(5)** Truck trailers manufactured or assembled in the state of Iowa provided the following are met:

a. *Width.* Not to exceed 10 feet 0 inches.

b. *Length.* Overall combination length must comply with Iowa Code section 321.457.

c. *Height.* Statutory: Not to exceed 13 feet 6 inches.

d. *Weight.* See rule 761—511.14(321,321E).

- e. *Speed.* Rescinded IAB 2/7/01, effective 3/14/01.
- f. *Roadway width.* At least 24 feet 0 inches.
- g. *Limited movement.* Movement shall be solely for the purpose of delivery or transfer from the point of manufacture or assembly to another point of manufacture or assembly within the state or to a point outside the state and shall be on the most direct route necessary for the movement.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.10 and 321E.29A.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20; ARC 5428C, IAB 2/10/21, effective 3/17/21]

**761—511.8(321,321E) Annual oversize/overweight permits.** Annual oversize/overweight permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. Travel is not allowed on the interstate. However, a carrier moving under this annual oversize/overweight permit may operate under the same restrictions as an annual permit under rule 511.7(321,321E) when the vehicle meets the dimensions required by that rule. Routing is subject to embargoed bridges and roads and posted speed limits. Annual oversize/overweight permits are issued for the following:

**511.8(1)** Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 13 feet 5 inches.
- b. *Length.* 120 feet 0 inches.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Routing.* The owner or operator shall select a route using a vertical clearance map, bridge embargo map, pavement restrictions map, and construction and travel restrictions map provided by the department. Route, detour and road embargo information may be found online at [www.511ia.org](http://www.511ia.org).

**511.8(2)** Reserved.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8 and 321E.9.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20; ARC 5428C, IAB 2/10/21, effective 3/17/21]

**761—511.9(321,321E) All-systems permits.** All-systems permits are issued by the vehicle and motor carrier services bureau for indivisible vehicles or indivisible loads for travel on the primary road system and specified city streets and county roads when the dimensions of the vehicle or load exceed statutory limits but the weight is within statutory limits. Routing is subject to embargoed bridges and roads and posted speed limits. The vehicle and motor carrier services bureau will provide a list of the authorized city streets and county roads. Permit holders shall consult with local officials when traveling on county roads or city streets for bridge embargo, vertical clearance, detour, and road construction information. These permits are issued for the following:

**511.9(1)** Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 12 feet 5 inches including appurtenances.
- b. *Length.* 120 feet 0 inches overall.
- c. *Height.* 13 feet 10 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Movement is allowed for unlimited distance; routing through the vehicle and motor carrier services bureau and city and county jurisdictions is not required.

**511.9(2)** Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 14 feet 6 inches.
- b. *Length.* 120 feet 0 inches overall.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* See rule 761—511.14(321,321E).

*e. Distance.* Movement is restricted to 50 miles unless trip routes are obtained from the vehicle and motor carrier services bureau and city and county jurisdictions or the route continues on at least four-lane roads. Trip routes are valid for five days.

**511.9(3)** Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. Width.* 16 feet 0 inches.
- b. Length.* 120 feet 0 inches.
- c. Height.* 15 feet 5 inches.
- d. Weight.* See rule 761—511.14(321,321E).
- e. Distance.* Trip routes must be obtained from the vehicle and motor carrier services bureau and city and county jurisdictions.

**511.9(4)** Rescinded IAB 1/23/02, effective 2/27/02.

**511.9(5)** Truck trailers manufactured or assembled in the state of Iowa provided the following are met:

- a. Width.* Not to exceed 10 feet 0 inches.
- b. Length.* Overall combination length must comply with Iowa Code section 321.457.
- c. Height.* Statutory: Not to exceed 13 feet 6 inches.
- d. Weight.* See rule 761—511.14(321,321E).
- e. Speed.* Rescinded IAB 2/7/01, effective 3/14/01.
- f. Roadway width.* At least 24 feet 0 inches.
- g. Limited movement.* Movement shall be solely for the purpose of delivery or transfer from the point of manufacture or assembly to another point of manufacture or assembly within the state or to a point outside the state and shall be on the most direct route necessary for the movement.

**511.9(6)** Rescinded IAB 2/10/21, effective 3/17/21.

**511.9(7)** Necessary trip routes must be obtained from the appropriate city and county jurisdictions.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8 and 321E.10.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20; ARC 5428C, IAB 2/10/21, effective 3/17/21]

**761—511.10(321,321E) Multitrip permits.** Multitrip permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. The permit shall be for unlimited trips along a specific route between one point of origin and one point of destination. Additional routes will require a new permit. Multitrip permits are issued for the following:

**511.10(1)** Multitrip permits may be issued for vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. Width.* 16 feet.
- b. Length.* 120 feet.
- c. Height.* 15 feet 5 inches.
- d. Weight.* 156,000 pounds total gross weight.
- e. Distance.* On routes specified by the permit-issuing authority.

**511.10(2)** Multitrip permits may be issued for all movements allowed under the single-trip permit provisions of rule 761—511.12(321,321E) provided the movement is within the size and weight limitations of subrule 511.10(1).

**511.10(3)** The dimensions listed on the permit are considered maximums. The movement is legal as long as the vehicle and load do not exceed these dimensions and the movement meets all other requirements of Iowa Code chapter 321E and this chapter of rules.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3 and 321E.9A.

[ARC 3193C, IAB 7/5/17, effective 8/9/17]

**761—511.11(321E) Compacted rubbish vehicle permits.** All compacted rubbish vehicle permits issued by the department shall be subject to the following:

**511.11(1)** Permits issued shall be in writing or in an electronic format, shall be carried in the vehicle for which the permit has been issued and shall be available for inspection by any peace officer or authorized agent of any permit-granting authority.

**511.11(2)** Movements by permit shall be allowed day and night, seven days a week including holidays.

**511.11(3)** Vehicles traveling under permit shall be registered for the gross weight or combined gross weight of the vehicle and load.

**511.11(4)** Vehicles under permit must be in compliance with posted bridge and road embargoes and speed limits.

**511.11(5)** Maximum axle weight allowed on the interstate system shall be 20,000 pounds on a single axle and 34,000 pounds on a tandem axle.

This rule is intended to implement Iowa Code section 321E.30.  
[ARC 3193C, IAB 7/5/17, effective 8/9/17]

**761—511.12(321,321E) Single-trip permits.** Single-trip permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. The permit shall be for a specific route between an origin and destination. Single-trip permits are issued for the following:

**511.12(1)** Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

*a. Width.* Limited to the maximum physical limitations and clearances of the roadway and infrastructure along the intended route of travel.

*b. Length.* Limited to the maximum physical limitations and clearances of the roadway along the intended route of travel.

*c. Height.* Limited only to the height of underpasses, bridges, power lines, and other established height restrictions. The carrier shall be required to contact affected public utilities when the height of the vehicle with load exceeds 16 feet 0 inches. At the discretion of the permit-issuing authority, a written verification may be required from the affected utility.

*d. Weight.* See rule 761—511.14(321,321E).

*e. Distance.* Limited at the discretion of the permit-issuing authority. The following factors shall be considered:

Road conditions; road width; traffic volume; weather conditions; and roadside obstructions, including bridges, signs and overhead obstructions.

**511.12(2)** Reserved.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3 and 321E.9.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20; ARC 5428C, IAB 2/10/21, effective 3/17/21]

**761—511.13(321,321E) Annual raw forest products permits.** Annual raw forest products permits are issued for vehicles transporting divisible loads of raw forest products when the weight exceeds statutory limits. Travel is not allowed on the interstate. The owner or operator shall select a route using the vertical clearance map, bridge embargo map, pavement restrictions map, and construction and travel restrictions map provided by the department. The owner or operator must contact the appropriate local authority for route approval to use this permit on county roads or city streets. Detour and road embargo information may be found online at: [www.511ia.org](http://www.511ia.org). Routing is subject to embargoed bridges and roads and posted speed limits. Annual raw forest products permits are issued for the following:

**511.13(1)** Vehicles with divisible loads of raw forest products provided the following are not exceeded:

*a. Width.* Statutory: 8 feet 6 inches.

*b. Length.* Limited to the maximum dimensions in Iowa Code section 321.457.

*c. Height.* Statutory: 13 feet 6 inches.

*d. Weight.* See rule 761—511.14(321,321E).

*e. Distance.* Unlimited.

**511.13(2)** Reserved.

This rule is intended to implement Iowa Code sections 321.463, 321E.2, 321E.3 and 321E.26.  
[ARC 4985C, IAB 3/11/20, effective 4/15/20]

**761—511.14(321,321E) Maximum axle weights and maximum gross weights for vehicles and loads moved under permit.****511.14(1)** *Annual and all-systems permits.*

a. For movement under an annual or all-systems permit, the axle weight and combined gross weight shall not exceed the limits found in Iowa Code section 321.463(3).

b. See subrule 511.14(5) for exceptions for special mobile equipment.

**511.14(2)** *Annual oversize/overweight permits or annual raw forest products permits.*

a. For movement under an annual oversize/overweight permit or an annual raw forest products permit, the gross weight on any axle shall not exceed 20,000 pounds, with a maximum of 156,000 pounds total gross weight.

b. See subrule 511.14(5) for exceptions for special mobile equipment.

**511.14(3)** *Multitrip permits.*

a. For movement under a multitrip permit, the gross weight on any axle shall not exceed 20,000 pounds with a maximum of 156,000 pounds total gross weight.

b. See subrule 511.14(5) for exceptions for special mobile equipment.

**511.14(4)** *Single-trip permits.*

a. For movement under a single-trip permit, the gross weight on any axle shall not exceed 20,000 pounds.

b. If the combined gross weight exceeds 100,000 pounds, a single-trip permit may be issued for the movement only if the permit-issuing authority determines that it would not cause undue damage to the road and is in the best interest of the public.

c. Cranes may have a maximum of 24,000 pounds per axle for movement under a single-trip permit. Routes must be reviewed by the permit-issuing authority prior to issuance.

d. See subrule 511.14(5) for exceptions for special mobile equipment.

**511.14(5)** *Special mobile equipment.* Special mobile equipment may have a gross weight of 36,000 pounds on any single axle equipped with minimum size 26.5-inch by 25-inch flotation pneumatic tires and a maximum gross weight of 20,000 pounds on any single axle equipped with minimum size 18-inch by 25-inch flotation pneumatic tires, provided that the total gross weight of the vehicle or a combination of vehicles does not exceed a maximum of 80,000 pounds for movement under an annual or all-systems permit and 126,000 pounds for movement under a single-trip, multitrip or annual oversize/overweight permit.

For tire sizes and weights allowed between the maximum and minimum indicated, the following formula shall apply: Axle weight = 20,000 pounds + (tire width - 18) × 1,882 pounds.

**511.14(6)** *Permitted tandem axle weights.*

a. Vehicles operating under an annual oversize permit, annual oversize/overweight permit, annual raw forest products permit, single-trip permit, or multitrip permit may have a gross weight not to exceed 46,000 pounds on a single-tandem axle of the truck tractor and a gross weight not to exceed 46,000 pounds on a single-tandem axle of the trailer or semitrailer if each axle of each tandem group has at least four tires.

b. The maximum weight of any single axle within a permitted tandem axle group shall be 24,000 pounds.

c. A permitted tandem axle shall not be a part of a larger group of axles whose centers are greater than 96 inches apart.

This rule is intended to implement Iowa Code sections 321.463, 321E.7, 321E.8, 321E.9, 321E.9A, 321E.26 and 321E.32.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4345C, IAB 3/13/19, effective 4/17/19; ARC 4985C, IAB 3/11/20, effective 4/15/20]

**761—511.15(321,321E) Movement of vehicles with divisible loads exceeding statutory size or weight limits.**

**511.15(1)** Vehicles with divisible loads exceeding statutory size or weight limits may be moved under a single-trip permit if the permit-issuing authority determines that a special or emergency situation warrants its issuance.

**511.15(2)** At the discretion of the permit-issuing authority, the combined gross weight may exceed the statutory weight, but the axle weights shall be subject to rule 761—511.14(321,321E).

**511.15(3)** Movement shall be subject to the routes established by the permit-issuing authority.

This rule is intended to implement Iowa Code sections 321.463 and 321E.29.  
[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20; ARC 5428C, IAB 2/10/21, effective 3/17/21]

**761—511.16(321E) Towing units.** The towing unit shall be a truck or truck tractor with dual wheels and with a gross vehicle weight rating of at least 10,000 pounds when towing mobile homes or loads exceeding 10,000 pounds.

This rule is intended to implement Iowa Code section 321.457.  
[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

**761—511.17(321E) Escorting.**

**511.17(1) Escort qualification.** An escort shall be a person aged 18 or over who possesses a valid driver's license which allows driving unaccompanied and who carries proof of public liability insurance in the amounts of \$100,000/\$200,000/\$50,000.

**511.17(2) Escorting responsibilities.**

*a.* The escorting vehicle shall be a mid-size automobile or motor truck with sufficient mobility to be able to assist in an emergency and designed to afford clear and unobstructed vision both front and rear. The escorting vehicle shall not be used to tow a trailer while performing escorting duties. In questionable cases the permit-issuing authority shall determine if a vehicle meets these conditions.

*b.* The escorting vehicle shall have a flashing or strobe amber light that is visible for at least 500 feet and provides 360° warning. While escorting a permit load, the light shall be mounted on top of the escort vehicle and shall be burning. Additional escort vehicle markings may be approved or required by the permit-issuing authority.

*c.* An 18-inch by 18-inch red or orange fluorescent flag shall be mounted on each corner of the front bumper of the escort vehicle.

*d.* The escort shall remain a distance of approximately 300 feet in front or to the rear of the load. However, when traveling within the corporate limits of a city, the escort shall maintain a reasonable and proper distance consistent with existing traffic conditions.

*e.* A separate escort shall be provided for each load hauled under escort.

*f.* All traffic laws and provisions of the oversize permit for the load shall be obeyed.

*g.* The escort shall not assume responsibility for stopping traffic. An on-duty peace officer, as defined in Iowa Code section 321.1, shall be contacted to provide any traffic control needed.

*h.* Immediately prior to an escorting trip, the escort shall determine that the escorting vehicle is in a safe operational condition and that the dimensions of the vehicle and load are in compliance with the permit issued.

*i.* Escort fees charged by state and local authorities shall not exceed \$250 per day per escort vehicle.

*j.* A pole used for measuring vertical clearances shall be mounted on the front escort vehicle. The escort shall be required to measure all vertical clearances whenever the height of the permitted vehicle exceeds 14 feet 6 inches up to and including 20 feet.

**511.17(3) Requirements for escorts, flags, signs and lights.** The following chart explains the minimum escort and warning devices required for vehicles operating under permit.

**Minimum Warning Devices and Escort Requirements  
For Vehicles Operating Under Permit**

	Flags/Signs	Lights	Escorts	
			4-Lane	2-Lane
<b>Length</b>				
75'1" up to and including 85'	yes	not required	not required	not required
Over 85' up to and including 120'	yes	yes	not required	not required
Over 120'	yes	not required	rear	rear
<b>Projections</b>				
Front: over 25'	not required	yes	not required	not required
Rear: over 4' up to and including 10'	flags only	not required	not required	not required
Rear: over 10'	flags only	yes	not required	not required
<b>Height</b>				
Over 14'6" up to and including 20'	yes	not required	front with a height pole	front with a height pole
<b>Weight</b>				
Over 80,000 lbs.	not required	yes	not required	not required
<b>Width</b>				
Over 8'6" up to 12'0"	yes	not required	not required	not required
Over 12'0" up to and including 14'6"	yes	not required	rear *	front *
Over 14'6" up to and including 16'6"	yes	not required	rear *	front
Over 16'6" up to and including 18'	yes	not required	rear	front

\*In lieu of an escort, a carrier can display an amber light or strobe light on the power unit and on the rear extremity of the vehicle or load.

yes = required

Definitions:

Flags - Red or orange fluorescent flags at least 18" square must be mounted as follows: one flag at each front corner of the towing unit and one flag at each rear corner of the load. In addition, there must be a flag at any additional protrusion in the width of the load.

Signs - A sign reading "Oversize Load" must be used. The sign must be at least 18" high by 7' long with a minimum of 10" black letters, with a 1½" stroke, on a yellow background, and mounted on the front bumper and on the rear of the load. The rear sign for mobile homes and factory-built structures must be mounted at least 7' above the highway surface, measuring from the bottom of the sign.

Lights - A flashing or strobe amber light that is visible for at least 500 feet and provides 360° warning must be mounted on the towing unit and be visible from front and rear. More than one light may be necessary.

The permit-issuing authority may require additional escorts when deemed necessary. The signs or warning devices must be removed or covered when the vehicle is within legal dimensions.

This rule is intended to implement Iowa Code sections 321E.14, 321E.24 and 321E.34.  
[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

**761—511.18(321,321E) Permit violations.** Permit violations are to be reported to the permit-issuing authority by the arresting officer and the permit holder. If a permit holder is found to have willfully violated permit provisions, the vehicle and motor carrier services bureau may, after notice and hearing, suspend, modify or revoke the permit privileges of the permit holder consistent with Iowa Code section 321E.20.

This rule is intended to implement Iowa Code sections 321.492, 321E.16 and 321E.20.  
[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

**761—511.19(321) Movement of combination vehicles on economic export corridors.**

**511.19(1) Designation of economic export corridors.**

a. The department may in its discretion establish economic export corridors for the transportation of goods or products manufactured in Iowa to or through the state of South Dakota and for the return of unladen semitrailers or unladen full trailers used for the transportation of those goods or products. An economic export corridor shall not include any segment of the interstate system or any part of the national network of highways identified pursuant to 23 CFR Part 658. However, if appropriate, the department may petition the Federal Highway Administration to remove a road or road segment from the national network of highways for the purpose of including it in an economic export corridor.

b. The department may initiate designation of economic export corridors, or a request for economic export corridor designation may be submitted to the department by an interested party. If a proposed economic export corridor includes any roads or road segments that are under the jurisdiction of a city or a county, a resolution from all relevant local jurisdictions must be submitted to the department indicating their support for economic export corridor designation. The resolution must include a description of the proposed economic export corridor under local jurisdiction.

c. The department shall exercise due regard for the safety of the traveling public and the protection of the highway surfaces and structures when establishing an economic export corridor. Factors to be considered include ability of the proposed economic export corridor to safely accommodate combinations of vehicles described in subrule 511.19(2), taking into account physical configurations and restrictions and traffic demands and capacity, as well as connection to markets that will benefit from the established economic export corridor.

d. The department will post established economic export corridors on the department's website.

**511.19(2) Combination vehicles that may be operated on an economic export corridor.**

a. In addition to combinations of vehicles lawful for operation on roads or road segments not designated as an economic export corridor, the following combinations of vehicles may be operated on an economic export corridor designated under subrule 511.19(1) if the combinations of vehicles meet the requirements in paragraph 511.19(2) "b":

(1) A truck tractor-semitrailer-semitrailer converted to a full trailer by use of a dolly equipped with a fifth wheel which is considered a part of the trailer for all purposes, and not a separate unit; or

(2) A truck tractor-semitrailer-full trailer; or

(3) A truck tractor-semitrailer-semitrailer combination, where the semitrailers are connected by a rigid frame extension including a fifth wheel connection point attached to the rear frame of the first semitrailer.

b. The combination of vehicles shall meet all of the following requirements:

(1) The length of the combination of vehicles, excluding the length of the truck tractor, shall not exceed 81½ feet.

(2) The length of either semitrailer or full trailer shall not exceed 45 feet.

(3) The weight of the second semitrailer or full trailer shall not exceed the weight of the first semitrailer by more than 3,000 pounds.

(4) The gross weight of the combination of vehicles shall not exceed 80,000 pounds and the combination of vehicles shall not exceed the gross axle weight limits of Iowa Code section 321.463(2).

(5) The load on each semitrailer or full trailer in the combination shall be an indivisible load. For the purpose of issuing permits for height or width under Iowa Code chapter 321E, the combination of

vehicles shall be considered an indivisible load so long as the load on each semitrailer or full trailer in the combination remains an indivisible load.

*c.* The length of the frame extension shall not be included when determining the overall length of the first semitrailer in a truck tractor-semi-trailer-semi-trailer combination in which the semi-trailers are connected by a rigid frame extension including a fifth wheel connection point attached to the rear frame of the first semitrailer.

*d.* For purposes of this subrule, “full trailer” means as defined in 49 CFR Section 390.5.

This rule is intended to implement Iowa Code section 321.457(2) “*n.*”

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

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[Filed ARC 5428C (Notice ARC 5292C, IAB 12/2/20), IAB 2/10/21, effective 3/17/21]

<sup>1</sup> Effective date of 511.2(1), 511.4(1) “*a.*,” 511.4(2) “*a.*” and “*b.*,” 511.5(1), 511.5(6) “*b.*”(3), 511.7, 511.8, 511.9(1) to 511.9(5), 511.14(2) “*g.*” and “*i.*,” 511.14(3) “*e.*,” delayed 70 days by the Administrative Rules Review Committee at its meeting held May 12, 1993; delay lifted by this Committee June 8, 1993, effective June 9, 1993.



CHAPTER 620  
OWI AND IMPLIED CONSENT  
[Prior to 6/3/87, Transportation Department[820]—(07,C)Ch 11]

**761—620.1(321J) Definitions.** Rescinded IAB 1/8/92, effective 2/12/92.

**761—620.2(321J) Information and location.** Applications, forms, information, assistance, and answers to questions relating to this chapter are available by mail from the Driver and Identification Services Bureau, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)244-8725; or by facsimile at (515)239-1837.

[ARC 4001C, IAB 9/12/18, effective 10/17/18; ARC 4760C, IAB 11/6/19, effective 12/11/19]

**761—620.3(321J) Issuance of temporary restricted license.**

**620.3(1) Eligibility and application.**

*a.* The department may issue a temporary restricted license to a person who is eligible under and for the purposes listed in Iowa Code chapter 321J. The department shall not issue a temporary restricted license to a person who is otherwise ineligible.

*b.* To apply for a temporary restricted license, an applicant shall, at any time before or during the revocation period, submit application Form 430400 to the driver and identification services bureau. The application form should be furnished by the arresting officer. It may also be obtained upon oral or written request to the driver and identification services bureau.

**620.3(2) Additional requirements.** A person applying for a temporary restricted license shall also comply with all of the following requirements:

*a.* Provide a description of all motor vehicles owned or operated under the temporary restricted license.

*b.* Submit proof of financial responsibility under Iowa Code chapter 321A for all motor vehicles owned or operated under the temporary restricted license.

*c.* Provide certification of installation of an approved ignition interlock device on every motor vehicle owned or operated.

*d.* Pay the \$200 civil penalty.

**620.3(3) Issuance and restrictions.**

*a.* The department shall not issue the temporary restricted license until the application is approved, all requirements are met, the applicable reinstatement and license fees have been paid, and the applicant has passed the appropriate examination for the type of vehicle to be operated under the temporary restricted license.

*b.* The department shall determine the restrictions to be imposed by the temporary restricted license. The licensee shall apply to the department in writing with a justification for any requested change in license restrictions.

**620.3(4) Denial.** A person who has been denied a temporary restricted license or who contests the restrictions imposed by the department may request an informal settlement conference by submitting a written request to the director of the driver and identification services bureau. Following an unsuccessful informal settlement or instead of that procedure, the person may request a contested case hearing in accordance with rule 761—620.4(321J).

[ARC 8024B, IAB 8/12/09, effective 7/14/09; ARC 8203B, IAB 10/7/09, effective 11/11/09; ARC 4001C, IAB 9/12/18, effective 10/17/18; ARC 4347C, IAB 3/13/19, effective 4/17/19; ARC 4760C, IAB 11/6/19, effective 12/11/19; ARC 5429C, IAB 2/10/21, effective 3/17/21]

**761—620.4(321J) Hearings and appeals.**

**620.4(1) Contested case hearing.**

*a.* A person may request a contested case hearing by checking the appropriate box on Form 432018 and submitting it to the department or by submitting a written request to the director of the driver and identification services bureau. The request shall include the person's name, date of birth, driver's license number, complete address and telephone number.

b. A request for a hearing to contest the denial of a temporary restricted license or to contest the restrictions may be submitted at any time.

c. A request for a hearing to contest a revocation shall be submitted within ten days after receipt of the revocation notice. The request shall be deemed timely submitted if it is delivered to the director of the driver and identification services bureau or properly addressed and postmarked within this time period.

d. Failure to timely request a hearing on a revocation is a waiver of the right to a hearing under Iowa Code chapter 321J, and the revocation shall become effective on the date specified in the revocation notice.

e. After a hearing, a written decision will be issued by the presiding officer.

**620.4(2) Appeal.** A decision by a presiding officer shall become the final decision of the department and shall be binding on the department and the person who requested the hearing unless either appeals the decision in accordance with this subrule.

a. The appeal shall be decided on the basis of the record made before the presiding officer in the contested case hearing and no additional evidence shall be presented.

b. The appeal shall include a statement of the specific issues presented for review and the precise ruling or relief requested.

c. An appeal of the presiding officer's decision shall be submitted in writing by sending the original and one copy of the appeal to the director of the driver and identification services bureau.

d. An appeal shall be deemed timely submitted if it is delivered to the director of the driver and identification services bureau or properly addressed and postmarked within ten days after receipt of the presiding officer's decision.

e. The director of the driver and identification services bureau shall forward the appeal to the director of transportation. The director of transportation may affirm, modify or reverse the decision of the presiding officer, or may remand the case to the presiding officer.

f. Failure to timely appeal a decision shall be considered a failure to exhaust administrative remedies.

**620.4(3) Final agency action.** The decision of the director of transportation shall be the final decision of the department and shall constitute final agency action for purposes of judicial review. No further steps are necessary to exhaust administrative remedies.

**620.4(4) Default.**

a. If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no continuance is granted, either enter a default decision or proceed with the hearing and render a decision in the absence of the party.

b. Any party may move for default against a party who has requested the contested case proceeding and who has failed to appear after proper service.

c. A default decision or a decision rendered on the merits after a party has failed to appear or participate in a contested case proceeding becomes final agency action unless, within ten days after receipt of the decision, either a motion to vacate is filed and served on the presiding officer and the other parties or an appeal of a decision on the merits is timely submitted in accordance with subrule 620.4(2). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate.

d. The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

e. Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate.

f. "Good cause" for the purpose of this rule means surprise, excusable neglect or unavoidable casualty.

g. A decision denying a motion to vacate is subject to further appeal in accordance with subrule 620.4(2).

h. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party in accordance with subrule 620.4(2).

*i.* If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

**620.4(5) *Petition to reopen a hearing.***

*a.* A petition to reopen a hearing pursuant to Iowa Code section 17A.16 shall be submitted in writing to the director of the driver and identification services bureau. If a petition is based on a court order, a copy of the court order shall be submitted with the petition. If a petition is based on new evidence, the petitioner shall submit a concise statement of the new evidence and the reason(s) for the unavailability of the evidence at the original hearing.

*b.* A petition to reopen a hearing may be submitted at any time even if a hearing to contest the revocation was not originally requested or held.

*c.* A person may appeal a denial of the petition to reopen. The appeal shall be deemed timely if it is delivered to the director of the driver and identification services bureau or properly addressed and postmarked within 20 days after issuance of the decision denying the petition to reopen.

[ARC 4001C, IAB 9/12/18, effective 10/17/18; ARC 4760C, IAB 11/6/19, effective 12/11/19]

**761—620.5(321J) Reinstatement.** The department may reinstate the license when the revocation has ended if the person has:

**620.5(1)** Filed proof of financial responsibility under Iowa Code chapter 321A for all motor vehicles to be operated.

**620.5(2)** Paid the \$200 civil penalty.

**620.5(3)** Provided proof of satisfactory completion of a course for drinking drivers and proof of completion of substance abuse evaluation and treatment or rehabilitation services on a form and in a manner approved by the department.

**620.5(4)** Successfully completed the required driver license examination.

**620.5(5)** Paid the specified reinstatement fee.

**620.5(6)** Paid the appropriate license or permit fee.

**620.5(7)** Provided, if required by Iowa Code section 321J.17(3), proof of installation of an approved ignition interlock device or proof the person remains in compliance with the ignition interlock device requirement if the device was installed for a temporary restricted license.

[ARC 4001C, IAB 9/12/18, effective 10/17/18; ARC 5429C, IAB 2/10/21, effective 3/17/21]

**761—620.6(321J) Issuance of temporary restricted license after revocation period has expired.** The department may issue a temporary restricted license to a person whose period of revocation under Iowa Code chapter 321J has expired but who has not met all the requirements for license reinstatement. The period of issuance shall be determined by the department, but it shall not exceed six months from the end of the original revocation period.

**620.6(1)** An applicant for a temporary restricted license under this rule must meet one of the following two conditions:

*a.* The applicant must demonstrate to the satisfaction of the department that a course for drinking drivers was not readily available to the person during the revocation period and that the applicant has enrolled in a course for drinking drivers. The applicant must furnish the dates the class will begin and end.

*b.* The applicant must demonstrate to the satisfaction of the department that substance abuse evaluation and treatment or rehabilitation services have not been completed because of an inability to schedule them or because they are ongoing.

**620.6(2)** An applicant for a temporary restricted license under this rule must meet all other conditions for issuance of a temporary restricted license under rule 761—620.3(321J) and Iowa Code section 321J.20, including installation of an ignition interlock device.

**761—620.7 to 620.9** Reserved.

**761—620.10(321J) Revocation for deferred judgment.** The revocation period under Iowa Code subsection 321J.4(3) shall be 90 days.

**761—620.11 to 620.14** Reserved.

**761—620.15(321J) Substance abuse evaluation and treatment or rehabilitation services.** When the department revokes a person’s license under Iowa Code chapter 321J, the department shall also order the person to submit to substance abuse evaluation and, if recommended, treatment or rehabilitation services. A provider of substance abuse evaluation and treatment or rehabilitation programs shall be licensed by the Iowa department of public health, division of substance abuse.

**620.15(1) Reporting.**

*a.* When a person who has been ordered to attend a substance abuse program has satisfactorily completed the program, the program provider shall electronically report completion to the department in a manner approved by the department.

*b.* Reporting to the department shall be in accordance with Iowa Code sections 125.37, 125.84 and 125.86 and the federal confidentiality regulations, “Confidentiality of Alcohol and Drug Abuse Patient Records,” 42 CFR Part 2.

**620.15(2) Payment.** Payment of substance abuse evaluation and treatment or rehabilitation costs shall be in accordance with Iowa department of public health rules.

[ARC 4001C, IAB 9/12/18, effective 10/17/18]

**761—620.16(321J) Drinking drivers course.** When the department revokes a person’s license under Iowa Code chapter 321J, the department shall order the person to enroll, attend and satisfactorily complete a course for drinking drivers, as provided in Iowa Code section 321J.22.

**620.16(1) Reporting.**

*a.* When a person who has been ordered to attend a drinking drivers course has successfully completed the course, the program provider under Iowa Code section 321J.22(2) “a” shall electronically report completion to the department in a manner approved by the department.

*b.* Reserved.

**620.16(2) Payment.** A person ordered to complete a drinking drivers course is responsible for payment of course fees and expenses in accordance with Iowa Code section 321J.22.

[ARC 4001C, IAB 9/12/18, effective 10/17/18]

**761—620.17(321J) Sobriety and drug monitoring program.** Rescinded ARC 5429C, IAB 2/10/21, effective 3/17/21.

These rules are intended to implement Iowa Code chapters 17A and 321J and sections 321.193, 321.201, 321.376 and 707.6A.

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[Filed ARC 5429C (Notice ARC 5311C, IAB 12/16/20), IAB 2/10/21, effective 3/17/21]



CHAPTER 32  
CHILD LABOR

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/21/98, see 347—Ch 32]

**875—32.1(92) Definitions.**

“*Filing date*” means the date a document is postmarked by the U.S. Postal Service, if the document is filed by mailing and the U.S. postmark is legible. For a document filed via facsimile transmission, “filing date” means the date the document is transmitted. For any other document, “filing date” means the date the document is received by the labor commissioner.

“*Migrant labor permit*” means an authorization to work as described in Iowa Code section 92.12.

“*Occupation or business operated by the child’s parents*,” as used in Iowa Code section 92.17(4), means a business operated by the child’s parent where the parent has control of the day-to-day operation of the business and is on the premises during the hours of the child’s employment.

“*Other work*,” as used in Iowa Code section 92.5(11), includes manual detasseling of corn when performed from power-operated detasseling machines.

“*Part-time*,” as used in Iowa Code section 92.17(2), means one-half of the maximum hours allowed under Iowa Code chapter 92.

“*Serious injury or illness*” means an illness or injury requiring medical attention beyond first aid.

“*Street trade*” means an occupation performed on any street including but not limited to newspaper sales, newspaper delivery, and door-to-door sales.

“*Street trades permit*” means an authorization as described in Iowa Code section 92.2 to perform a street trade.

“*Week*,” as used in Iowa Code section 92.7, means Sunday through Saturday.

“*Willfully volunteering*” means performing service for a charitable or public purpose without promise, expectation, or receipt of compensation. A child shall be considered a volunteer only if services are offered freely and without direct or implied pressure or coercion from an employer. A child shall not be considered a volunteer if the child is otherwise employed by the same charitable or public organization to perform the same type of services as those for which the child proposes to volunteer. A child shall not be considered a volunteer while working in commercial activities for a nonprofit organization.

“*Working days*,” as used in rule 875—32.12(92), means Mondays through Fridays but shall not include Saturdays, Sundays or federal or state holidays. In computing 15 working days, the day of receipt of any notice shall not be included, and the last day of the 15 working days shall be included.

“*Work permit*” means an authorization to work as described in Iowa Code section 92.10.

This rule is intended to implement Iowa Code chapter 92 as amended by 2019 Iowa Acts, Senate File 337.

[ARC 8300B, IAB 11/18/09, effective 1/1/10; ARC 2134C, IAB 9/2/15, effective 10/7/15; ARC 4640C, IAB 8/28/19, effective 10/2/19; Editorial change: IAC Supplement 2/10/21]

**875—32.2(92) Permits and certificates of age.**

**32.2(1) *When permits and certificates of age are required.*** A street trades permit is required for a child who is at least 10 years of age, who is less than 16 years of age, and who desires to work in a street trade. A migrant labor permit is required for a child who is at least 12 years of age, who is less than 16 years of age, and who desires to perform migratory labor as defined in Iowa Code section 92.18. A work permit is required for a child who is 14 or 15 years of age and who desires to perform work other than street trades and migratory labor. An employer may require a certificate of age for a child 16 or 17 years of age.

**32.2(2) *How permits and certificates of age are issued.*** The Iowa Child Labor Application/Work Permit must be completed before the minor begins work. The Iowa Child Labor Application/Work Permit is available at the labor division’s website. The following procedure shall be used to complete the form:

a. The minor, parent, guardian, or custodian shall obtain evidence as set forth in Iowa Code section 92.11(2) establishing the minor's age.

b. The minor and a parent, guardian, custodian, or head of migrant family shall each complete the applicable portion of the form.

c. The employer shall review, copy, and return the document establishing the minor's age; review permitted hours and duties; complete the employer's portion of the form; and file the form with the labor commissioner.

d. The permit shall be submitted to the office of the labor commissioner within three days after the minor begins work. The day after the minor begins work shall be the first day. If the third day is a Sunday, the form may be filed on the fourth day.

This rule is intended to implement Iowa Code chapter 92.

[ARC 8300B, IAB 11/18/09, effective 1/1/10; ARC 2134C, IAB 9/2/15, effective 10/7/15; ARC 3339C, IAB 9/27/17, effective 11/1/17; ARC 4639C, IAB 8/28/19, effective 10/2/19]

**875—32.3** and **32.4** Reserved.

**875—32.5(92) Other work.** Rescinded ARC 2134C, IAB 9/2/15, effective 10/7/15.

**875—32.6** Reserved.

**875—32.7(92) Workweek.** Rescinded ARC 2134C, IAB 9/2/15, effective 10/7/15.

**875—32.8(92) Terms.** The terms used in Iowa Code section 92.8 are defined and applied as specified in this rule.

**32.8(1)** "*Occupations in or about plants or establishments manufacturing or storing explosives or articles containing explosive components*" means:

a. All occupations in or about any plant or establishment (other than retail establishments or plants or establishments of the type described in subrule "b.") manufacturing or storing explosives or articles containing explosive components except where the occupation is performed in a "nonexplosive area."

b. The following occupations in or about any plant or establishment manufacturing or storing small-arms ammunition not exceeding .60 caliber in size, shotgun shells, or blasting caps when manufactured or stored in conjunction with the manufacture of small-arms ammunition:

(1) All occupations involved in the manufacturing, mixing, transporting, or handling of explosive compounds in the manufacture of small-arms ammunition and all other occupations requiring the performance of any duties in the explosives area in which explosive compounds are manufactured or mixed.

(2) All occupations involved in the manufacturing, transporting, or handling of primers and all other occupations requiring the performance of any duties in the same building in which primers are manufactured.

(3) All occupations involved in the priming of cartridges and all other occupations requiring the performance of any duties in the same workroom in which rim-fire cartridges are primed.

(4) All occupations involved in the plate loading of cartridges and in the operation of automatic loading machines.

(5) All occupations involved in the loading, inspecting, packing, shipping and storage of blasting caps.

c. Definitions.

"*Explosives*" and "*articles containing explosive components*" means and includes ammunition, black powder, blasting caps, fireworks, high explosives, primers, smokeless powder, and all goods classified and defined as explosives by the Interstate Commerce Commission in regulations for the transportation of explosives and other dangerous substances by common carriers (49 CFR Parts 71-78, in effect July 1, 1987).

"*Nonexplosive area*" means an area where none of the work performed in the area involves the handling or use of explosives; the area is separated from the explosives area by a distance not less than

that prescribed in the American Table of Distances for the protection of inhabited buildings; the area is separated from the explosives area by a fence or is otherwise located so that it constitutes a definite designated area; and satisfactory controls have been established to prevent employees under 18 years of age within the area from entering any area in or about the plant which does not meet the criteria of this definition.

*“Plant or establishment manufacturing or storing explosives or articles containing explosive components”* means the land with all the buildings and other structures thereon used in connection with the manufacturing or processing or storing of explosives or articles containing explosive components.

This subrule is intended to implement Iowa Code section 92.8(1).

**32.8(2)** *“Occupations of motor vehicle driver and helper”* means occupations of motor vehicle driver and outside helper on any public road, highway, in or about any mine (including open pit mine or quarry), place where logging or sawmill operations are in progress, or in any excavation.

a. *“Occupations of motor vehicle driver and helper”* does not include:

(1) Incidental and occasional driving where the operation of automobiles or trucks does not exceed 6,000 pounds gross vehicle weight if the driving is restricted to daylight hours; the operation is only occasional and incidental to the child’s employment; the child holds a state license valid for the type of driving involved in the job which is to be performed and has completed a state-approved driver education course; the vehicle is equipped with a seat belt or similar device for the driver and for each helper; and the employer has instructed each child that the belts or other devices must be used. This exemption shall not be applicable to any occupation of a motor vehicle driver which involves the towing of vehicles.

(2) During daylight hours, a child who is 16 or 17 years of age driving a golf cart on or across a golf course or a private or public roadway that crosses a golf course if the child has passed a state-approved driver education class; the child holds a full license, an intermediate license, or a Class C noncommercial operator’s license; and the child has been trained on use of the golf cart.

b. Definitions.

*“Driver”* means any individual who, in the course of employment, drives a motor vehicle at any time.

*“Gross vehicle weight”* includes the truck chassis with lubricants, water and full tank or tanks of fuel, plus the weight of the cab or driver’s compartment, body and special chassis, and body equipment and payload.

*“Motor vehicle”* means any automobile, truck, truck-tractor, trailer, semitrailer, motorcycle or similar vehicle propelled or drawn by mechanical power and designed for use as a means of transportation but shall not include any vehicle operated exclusively on rails.

*“Outside helper”* means any individual, other than a driver, whose work includes riding on a motor vehicle outside the cab for the purpose of assisting in transporting or delivering goods.

This subrule is intended to implement Iowa Code section 92.8(2).

**32.8(3)** *“Occupations involved in logging occupations and occupations in the operation of any sawmill, lath mill, shingle mill, or cooperage-stock mill”* means all occupations with the following exceptions:

a. Exceptions applying to logging:

(1) Work in offices or in repair or maintenance shops.

(2) Work in the construction, operation, repair or maintenance of living and administrative quarters or logging camps.

(3) Work in timber cruising, surveying, or logging-engineering parties; work in the repair or maintenance of roads, railroads, or flumes; work in forest protection, such as clearing fire trails or roads, piling and burning slash, maintaining firefighting equipment, constructing and maintaining telephone lines, or acting as fire lookout or fire patrol person away from the actual logging operations. This exception shall not apply to the felling or bucking of timber, the collecting or transporting of logs, the operation of power-driven machinery, the handling or use of explosives, and work on trestles.

(4) Peeling of fence posts, pulpwood, chemical wood, excelsior wood, cordwood, or similar products, when not done in conjunction with and at the same time and place as other logging occupations prohibited by this subrule.

- (5) Work in the feeding or care of animals.
- b. Exceptions applying to the operation of any permanent sawmill or the operation of any lath mill, shingle mill, or cooperage-stock mill:
  - (1) Work in offices or in repair or maintenance shops.
  - (2) Straightening, marking, or tallying lumber on the dry chain or the dry drop sorter.
  - (3) Pulling lumber from the dry chain.
  - (4) Cleanup in the lumberyard.
  - (5) Piling, handling, or shipping of cooperage stock in yards or storage sheds, other than operating or assisting in the operation of power-driven equipment.
  - (6) Clerical work in yards or shipping sheds, such as done by order persons, tally persons, and shipping clerks.
  - (7) Cleanup work outside shake and shingle mills, except when the mill is in operation.
  - (8) Splitting shakes manually from precut and split blocks with a froe and mallet, except inside the mill building or cover.
  - (9) Packing shakes into bundles when done in conjunction with splitting shakes manually with a froe and mallet, except inside the mill building or cover.
  - (10) Manual loading of bundles of shingles or shakes into trucks or railroad cars, provided that the employer has on file a statement from a licensed doctor of medicine or osteopathy certifying the minor capable of performing this work without injury. The exceptions in paragraph "b," subparagraphs (1) to (10), do not apply to a portable sawmill the lumberyard of which is used only for the temporary storage of green lumber and in connection with which no office or repair or maintenance shop is ordinarily maintained and work which entails entering the sawmill building.

Definitions.

*"All occupations in logging"* means all work performed in connection with the felling of timbers; the bucking or converting of timber into logs, poles, piles, ties, bolts, pulpwood, chemical wood, excelsior wood, cordwood, fence posts, or similar products; the collecting, skidding, yarding, loading, transporting and unloading of these products in connection with logging; the constructing, repairing and maintaining of roads, railroads, flumes, or camps used in connection with logging; the moving, installing, rigging, and maintenance of machinery or equipment used in logging; and other work performed in connection with logging. The term shall not apply to work performed in timber culture, timber-stand improvement, or in emergency firefighting.

*"All occupations in the operation of any sawmill, lath mill, shingle mill, or cooperage-stock mill"* means all work performed in or about any mill in connection with storing of logs and bolts; converting logs or bolts into sawn lumber, laths, shingles, or cooperage stock; storing, drying, and shipping lumber, laths, shingles, cooperage stock, or other products of the mills and other work performed in connection with the operation of any sawmill, lath mill, shingle mill, or cooperage-stock mill. The term shall not include work performed in the planing-mill department or other remanufacturing departments of any sawmill, or in any planing mill or remanufacturing plant not a part of a sawmill.

This subrule is intended to implement Iowa Code section 92.8(3).

**32.8(4)** *"Occupations involved in the operation of power-driven woodworking machines"* means operating power-driven woodworking machines including supervision or controlling the operation of the machines, feeding material into the machines, and helping the operator to feed material into the machines, but not including the placing of material on a moving chain or in a hopper or slide for automatic feeding. Also included are occupations of setting up, adjusting, repairing, oiling or cleaning power-driven woodworking machines and the operations of off-bearing from circular saws and from guillotine-action veneer clippers.

Definitions.

*"Off-bearing"* means the removal of material or refuse directly from a saw table or from the point of operation. Operations not considered as off-bearing within the intent of this subrule include:

- a. The removal of material or refuse from a circular saw or guillotine-action veneer clipper where the material or refuse has been conveyed away from the saw table or point of operation by a gravity chute or by some mechanical means such as a moving belt or expansion roller, and

b. The following operations when they do not involve the removal of material or refuse directly from a saw table or from the point of operation; the carrying, moving or transporting of materials from one machine to another or from one part of a plant to another; the piling, stacking, or arranging of materials for feeding into a machine by another person; and the sorting, tying, bundling or loading of materials.

*“Power-driven woodworking machines”* means all fixed or portable machines or tools driven by power and used or designed for cutting, shaping, forming, surfacing, nailing, stapling, wire stitching, fastening or otherwise assembling, pressing or printing wood or veneer.

This subrule is intended to implement Iowa Code section 92.8(4).

**32.8(5)** *“Occupations involving exposure to radioactive substances and to ionizing radiations”* means occupation in any workroom in which radium is stored or used in the manufacture of self-luminous compound; self-luminous compound is made, processed or packaged; self-luminous compound is stored, used or worked upon; incandescent mantles are made from fabric and solutions containing thorium salts, or are processed or packaged; and other radioactive substances are present in the air in average concentrations exceeding 10 percent of the maximum permissible concentrations in the air recommended for occupational exposure by the National Committee on Radiation Protection, as set forth in the 40-hour week column of Table One of the National Bureau of Standards Handbook No. 69 entitled *“Maximum Permissible Body Burdens and Maximum Permissible Concentrations of Radionuclides in Air and in Water for Occupational Exposure,”* June 5, 1959.

Also included is any other work which involves exposure to ionizing radiations in excess of 0.5 rem per year.

Definitions.

*“Ionizing radiations”* means alpha and beta particles, electrons, protons, neutrons, gamma and X-ray and all other radiations which produce ionizations directly or indirectly, but does not include electromagnetic radiations other than gamma and X-ray.

*“Self-luminous compound”* means any mixture of phosphorescent material and radium, mesothorium or other radioactive element.

*“Workroom”* means the entire area bounded by walls of solid material and extending from floor to ceiling.

This subrule is intended to implement Iowa Code section 92.8(5).

**32.8(6)** *“Occupations involved in the operation of elevators and other power-driven hoisting apparatus”* means:

a. Work of operating an elevator, crane, derrick, hoist, or high-lift truck, except operating an unattended automatic operation passenger elevator or an electric or air-operated hoist not exceeding one-ton capacity.

b. Work which involves riding on a manlift or on a freight elevator, except a freight elevator operated by an assigned operator.

c. Work of assisting in the operation of a crane, derrick or hoist performed by crane hookers, crane chasers, hookers-on, riggers, rigger helpers, and like occupations.

d. Exception. Iowa Code section 92.8(6) shall not prohibit the operation of an automatic elevator and an automatic signal operation elevator provided that the exposed portion of the car interior (exclusive of vents and other necessary small openings), the car door and the hoistway doors are constructed of solid surfaces without any opening through which a part of the body may extend; all hoistway openings at floor level have doors which are interlocked with the car door so as to prevent the car from starting until all doors are closed and locked; the elevator (other than hydraulic elevators) is equipped with a device which will stop and hold the car in case of overspeed or if the cable slackens or breaks; and the elevator is equipped with upper and lower travel limit devices which will normally bring the car to rest at either terminal and a final limit switch which will prevent the movement in either direction and will open in case of excessive over-travel by the car.

e. Definitions.

*“Automatic elevator”* means any passenger elevator, a freight elevator or a combination passenger-freight elevator, the operation of which is controlled by push buttons in a manner that the

starting, going to the landing selected, leveling and holding, and the opening and closing of the car and hoistway doors are entirely automatic.

*“Automatic signal operation elevator”* means an elevator which is started in response to the operation of a switch (such as a lever or push button) in the car which when operated by the operator actuates a starting device that automatically closes the car and hoistway doors—from this point on, the movement of the car to the landing selected, leveling and holding when it gets there, and the opening of the car and hoistway doors are entirely automatic.

*“Crane”* means any power-driven machine for lifting and lowering a load and moving it horizontally, in which the hoisting mechanism is an integral part of the machine. The term shall include all types of cranes, such as cantilever gantry, crawler, gantry, hammerhead, ingot pouring, jib, locomotive, motor truck, overhead traveling, pillar jib, pintle, portal, semigantry, semiportal, storage bridge, tower, walking jib, and wall cranes.

*“Derrick”* means any power-driven apparatus consisting of a mast or equivalent members held at the top by guys or braces, with or without a boom, for use with a hoisting mechanism or operating ropes. The term shall include all types of derricks, such as A-frame, breast, Chicago boom, gin-pole, guy and stiff-leg derrick.

*“Elevator”* means any power-driven hoisting or lowering mechanism equipped with a car or platform which moves in guides in a substantially vertical direction. The term shall include both passenger and freight elevators, (including portable elevators or tiering machines), but shall not include dumbwaiters.

*“High-lift truck”* means any power-driven industrial type of truck used for lateral transportation that is equipped with a power-operated lifting device usually in the form of a fork or platform capable of tiering loaded pallets or skids one above the other. Instead of a fork or platform, the lifting device may consist of a ram, scoop, shovel, crane, revolving fork, or other attachments for handling specific loads. The term shall mean and include high-lift trucks known as fork lifts, fork trucks, fork-lift trucks, tiering trucks, or stacking trucks, but shall not mean low-lift trucks or low-lift platform trucks that are designed for the transportation of, but not the tiering of, material.

*“Hoist”* means any power-driven apparatus for raising or lowering a load by the application of a pulling force that does not include a car or platform running in guides. The term includes all types of hoists, such as base-mounted electric, clevis suspension, hook suspension, monorail, overhead electric, simple drum and trolley suspension hoists.

*“Manlift”* means any device intended for the conveyance of persons which consists of platforms or brackets mounted on, or attached to, an endless belt, cable, chain or similar method of suspension; the belt, cable or chain operating in a substantially vertical direction and being supported by and driven through pulleys, sheaves or sprockets at the top and bottom.

This subrule is intended to implement Iowa Code section 92.8(6).

**32.8(7)** *“Occupations involved in the operation of power-driven metal forming, punching and shearing machines”* means occupations of operator or helper on the following power-driven metal forming, punching, and shearing machines.

a. All rolling machines, such as beading, straightening, corrugating, flanging, or bending rolls; and hot or cold rolling mills.

b. All pressing or punching machines, such as punch presses except those provided with full automatic feed and ejection and with a fixed barrier guard to prevent the hands or fingers of the operator from entering the area between the dies; power presses; and plate punches.

c. All bending machines, such as apron brakes and press brakes.

d. All hammering machines, such as drop hammers and power hammers.

e. All shearing machines, such as guillotine or squaring shears, alligator shears and rotary shears.

Also included are the occupations of setting up, adjusting, repairing, oiling, or cleaning these machines including those with automatic feed and ejection.

*“Forming, punching and shearing machines”* means power-driven metal-working machines, other than machine tools, which change the shape of or cut metal by means of tools, such as dies, rolls or knives which are mounted on rams, plungers or other moving parts. Types of forming, punching, and

shearing machines enumerated in this subrule are the machines to which the designation is by custom applied.

“*Helper*” means a person who assists in the operation of a machine covered by this subrule by helping place materials into or remove them from the machine.

“*Operator*” means a person who operates a machine covered by this subrule by performing functions such as starting or stopping the machine, placing materials into or removing them from the machine, or any other functions directly involved in operation of the machine.

This subrule is intended to implement Iowa Code section 92.8(7).

**32.8(8)** “*Occupations in connection with mining*” means all work performed underground in mines and quarries; underground working, open-pit, or surface part of any coal-mining plant that contribute to the extraction, grading, cleaning, or other handling of coal; on the surface at underground mines and underground quarries; in or about open-cut mines, open quarries, clay pits, and sand and gravel operations; at or about placer mining operations; at or about dredging operations for clay, sand or gravel; at or about bore-hole mining operations; in or about all metal mills, washer plants, or grinding mills reducing the bulk of the extracted minerals; and at or about any other crushing, grinding, screening, sizing, washing or cleaning operations performed upon the extracted minerals except where the operations are performed as a part of a manufacturing process.

The term “occupations in connection with mining” shall not include:

a. Work performed in subsequent manufacturing or processing operations, such as work performed in smelters, electro-metallurgical plants, refineries, reduction plants, cement mills, plants where quarried stone is cut, sanded and further processed, or plants manufacturing clay, glass or ceramic products.

b. Work performed in connection with petroleum production, in natural gas production, or in dredging operations which are not a part of mining operations, such as dredging for construction or navigation purposes.

c. Work in offices, in the warehouse or supply house, in the change house, in the laboratory, and in repair or maintenance shops not located underground.

d. Work in the operation and maintenance of living quarters.

e. Work outside the mine in surveying, in the repair and maintenance of roads, and in general cleanup about the mine property such as clearing brush and digging drainage ditches.

f. Work of track crews in the building and maintaining of sections of railroad track located in those areas of open-cut metal mines where mining and haulage activities are not being conducted at the time and place that the building and maintenance work is being done.

g. Work in or about surface placer mining operations other than placer dredging operations and hydraulic placer mining operations.

h. Work in metal mills other than in mercury-recovery mills or mills using the cyanide process involving the operation of jigs, sludge tables, flotation cells, or drier-filters; hand-sorting at picking table or picking belts; or general cleanup.

Nothing in this subrule shall be construed to permit any employment of minors in any other occupation otherwise prohibited by Iowa Code chapter 92.

This subrule is intended to implement Iowa Code section 92.8(8).

**32.8(9)** “*Occupations in or about slaughtering and meat packing establishments and rendering plants*” means:

a. All occupations on the killing floor, in curing cellars, and in hide cellars, except the work of messengers, runners, hand truckers and similar occupations which require entering workrooms or workplaces infrequently and for short periods of time.

b. All occupations involved in the recovery of lard and oils, except packaging and shipping of the products and the operation of lard-roll machines.

c. All occupations involved in tankage or rendering of dead animals, animal offal, animal fats, scrap meats, blood, and bones into stock feeds, tallow, inedible greases, fertilizer ingredients, and similar products.

*d.* All occupations involved in the operation or feeding of the following power-driven meat processing machines, including the occupations of setting-up, adjusting, repairing, oiling, or cleaning the machines regardless of the product being processed by these machines (including, for example, the slicing in a retail delicatessen of meat, poultry, seafood, bread, vegetables, or cheese, etc.):

1. Meat patty forming machines, meat and bone cutting saws, knives (except bacon-slicing machines), head splitters, and guillotine cutters;
2. Snout pullers and jaw pullers;
3. Skinning machines;
4. Horizontal rotary washing machines;
5. Casing-cleaning machines such as crushing, stripping, and finishing machines;
6. Grinding, mixing, chopping, and hashing machines; and
7. Presses (except belly-rolling machines).

*e.* All boning occupations.

*f.* All occupations involving the pushing or dropping of any suspended carcass, half carcass, or quarter carcass.

*g.* All occupations involving hand-lifting or hand-carrying any carcass or half carcass of beef, pork, or horse, or any quarter carcass of beef or horse.

Definitions.

*“Boning occupation”* means the removal of bones from meat cuts. It does not include cutting, scraping or trimming meat from cuts containing bones.

*“Curing cellar”* means the workroom or workplace which is primarily devoted to the preservation and flavoring of meat by curing materials. It does not include the workroom or workplace where meats are smoked.

*“Hide cellar”* means the workroom or workplace where hides are graded, trimmed, salted, and otherwise cured.

*“Killing floor”* means the workroom or workplace where cattle, calves, hogs, sheep, lambs, goats, or horses are immobilized, shackled, or killed, and the carcasses are dressed prior to chilling.

*“Rendering plants”* means establishments engaged in the conversion of dead animals, animal offal, animal fats, scrap meats, blood, and bones into stock feeds, tallow, inedible greases, fertilizer ingredients and similar products.

*“Slaughtering and meat packing establishments”* means places in or about which cattle, calves, hogs, sheep, lambs, goats, or horses, poultry, rabbits or small game are killed, processed or butchered and establishments which manufacture or process meat products or sausage casings from these animals.

This subrule is intended to implement Iowa Code section 92.8(9).

**32.8(10)** *“Occupations involved in the operation of certain power-driven bakery machines”* means the occupations of operating, assisting to operate or setting up, adjusting, repairing, oiling, or cleaning any horizontal or vertical dough mixer; batter mixer; bread dividing, rounding, or molding machine; dough brake; dough sheeter; combination bread slicing and wrapping machines; or cake cutting band saw and the occupations of setting up or adjusting a cookie or cracker machine.

This subrule is intended to implement Iowa Code section 92.8(10).

**32.8(11)** *“Occupations involved in the operations of paper-products machines”* means operating or assisting to operate any of the following power-driven paper-products machines and includes:

*a.* Arm-type wire stitcher or stapler, circular or band saw, corner cutter or mitering machine, corrugating and single- or double-facing machine, envelope die-cutting press, guillotine paper cutter or shear, horizontal bar scorer, laminating or combining machine, sheeting machine, scrap-paper baler, or vertical slotter.

*b.* Platen die-cutting press, platen printing press, or punch press which involves hand feeding of the machine.

*c.* The occupations of setting up, adjusting, repairing, oiling, or cleaning the machines in paragraphs *“a”* and *“b”* of this subrule including those which do not involve hand feeding.

Definitions.

*“Operating or assisting to operate”* means all work which involves starting or stopping a machine covered by this subrule, placing materials into or removing them from the machine, or any other work directly involved in operating the machine.

*“Paper-products machine”* means power-driven machines used in:

1. The remanufacture or conversion of paper or pulp into a finished product, including the preparation of materials for recycling.
2. The preparation of materials for disposal. The term applies to the machines whether they are used in establishments that manufacture converted paper or pulp products, or in any other type of manufacturing or nonmanufacturing establishments.

This subrule is intended to implement Iowa Code section 92.8(11).

**32.8(12)** *“Occupations involved in the manufacture of brick”* means the manufacture of brick, tile and related products and includes the manufacture of clay construction products and of silica refractory products and includes:

a. All work in or about establishments in which clay construction products are manufactured, except work in storage and shippings; work in offices, laboratories, and storerooms; and work in the drying departments of plants manufacturing sewer pipe.

b. All work in or about establishments in which silica brick or other silica refractories are manufactured, except work in offices.

c. Nothing in this subrule shall be construed to permit any employment of minors in any other occupation otherwise prohibited by Iowa Code chapter 92.

Definitions.

*“Clay construction products”* means brick, hollow structural tile, sewer pipe and kindred products, refractories, and other clay products such as architectural terra cotta, glazed structural tile, roofing tile, stove lining, chimney pipes and tops, wall coping, and drain tile. It does not include nonstructural-bearing clay products such as ceramic floor and wall tile, mosaic tile, glazed and enameled tile, faience, and similar tile, nor nonclay construction products such as sand-lime brick, glass brick, or nonclay refractories.

*“Silica brick or other silica refractories”* means refractory products produced from raw materials containing free silica as its main constituent.

This subrule is intended to implement Iowa Code section 92.8(12).

**32.8(13)** *“Occupations involved in the operation of circular saws, band saws, and guillotine shears”* means:

a. Occupations of operator of or helper on power-driven fixed or portable circular saws, band saws, and guillotine shears except machines equipped with full automatic feed and ejection.

b. The occupations of setting-up, adjusting, repairing, oiling, or cleaning circular saws, band saws, or guillotine shears.

Definitions.

*“Band saw”* means a machine equipped with an endless steel band having a continuous series of notches or teeth, running over wheels or pulleys, and used for sawing materials.

*“Circular saw”* means a machine equipped with an endless steel disc and having a continuous series of notches or teeth on the periphery, mounted on shafting, and used for sawing materials.

*“Guillotine shear”* means a machine equipped with a movable blade operated vertically and used to shear materials. The term shall not include other types of shearing machines, using a different form of shearing action, such as alligator shears or circular shears.

*“Helper”* means a person who assists in the operation of a machine covered by this subrule by helping place materials into or remove them from the machine.

*“Machines equipped with full automatic feed and ejection”* means machines covered by this subrule which are equipped with devices for full automatic feeding and ejection and with a fixed barrier guard to prevent completely the operator or helper from placing any body part in the point-of-operation area.

“*Operator*” means a person who operates a machine covered by this subrule by performing functions such as starting or stopping the machine, placing materials into or removing them from the machine, or any other function directly involved in the operation of the machine.

This subrule is intended to implement Iowa Code section 92.8(13).

**32.8(14)** “*Wrecking, demolition and shipbreaking operations*” means all work, including cleanup and salvage work, performed at the site of the total or partial razing, demolishing, or dismantling of a building, bridge, steeple, tower, chimney, other structure, ship or other vessel.

This subrule is intended to implement Iowa Code section 92.8(14).

**32.8(15)** “*Roofing operations*” means all work performed in connection with the application of weatherproofing materials and substances (such as tar or pitch, asphalt prepared paper, tile, slate, metal, translucent materials, and shingles of asbestos, asphalt or wood) to roofs of buildings or other structures. The term also includes all work performed in connection with the installation of roofs, including related metal work such as flashing; and alterations, additions, maintenance and repair, including painting and coating, of existing roofs. The term shall not include gutter and downspout work; the construction of the sheathing or base of roofs; or the installation of television antennas, air conditioners, exhaust and ventilating equipment or similar appliances attached to roofs.

This subrule is intended to implement Iowa Code section 92.8(15).

**32.8(16)** “*Excavation occupations*” means all occupations involved with:

a. Excavating, working in, or backfilling (refilling) trenches, except manually excavated or manually backfilling trenches that do not exceed four feet in depth at any point or working in trenches that do not exceed four feet in depth at any point.

b. Excavating for buildings or other structures or working in the excavations, except manually excavating to a depth not exceeding four feet below any ground surface adjoining the excavation, working in an excavation not exceeding four feet in depth, or working in an excavation where the side walls are shored or sloped to the angle or repose.

c. Working within tunnels prior to the completion of all driving and shoring operations.

d. Working within shafts prior to the completion of all sinking and shoring operations.

This subrule is intended to implement Iowa Code section 92.8(16).

**32.8(17) to 32.8(20)** Reserved.

**32.8(21)** Hazardous occupations prohibited by the labor commissioner include the following:

a. Occupations involved in the operation of power cutters on corn detasseling machines.

b. Occupations involved in the driving of power-driven detasseling machines unless the driver has a valid driver’s license or a certificate issued by the Federal Extension Service showing that the driver has completed a 4-H farm and machinery program.

This subrule is intended to implement Iowa Code section 92.8(21).

This rule is intended to implement Iowa Code section 92.8.

[ARC 9963B, IAB 1/11/12, effective 2/15/12; ARC 5022C, IAB 4/8/20, effective 5/13/20]

**875—32.9 and 32.10** Reserved.

**875—32.11(92) Civil penalty calculation.** An employer who violates this chapter or Iowa Code chapter 92 is subject to a civil penalty of not more than \$10,000 per violation as set forth in this rule. The labor commissioner may refer a violation to the appropriate authority for criminal prosecution in addition to assessing a civil penalty.

**32.11(1) Counting the number of violations.** Violations shall be counted as follows:

a. Each item of inaccurate information on each Iowa Child Labor Application/Work Permit shall be a separate violation.

b. Each day that a child works without a permit, works too many hours, works at a prohibited time, or works in a prohibited occupation shall be a separate violation.

c. If an employer completes the Iowa Child Labor Application/Work Permit but fails to file it by the deadline, each day that the minor works after the deadline shall be a separate violation.

**32.11(2) Determining whether a violation is a repeat violation.** The higher penalty amounts outlined in subrules 32.11(3) through 32.11(5) for repeat instances may be assessed by the labor commissioner if citations regarding the earlier instance or instances are final action and occurred less than five years before.

**32.11(3) Permit violations.**

*a. Inaccurate information on a street trades permit, migrant labor permit, or work permit.* Insignificant misspellings and typographical errors shall not be considered inaccurate information. A repeated instance of inaccurate information may result in a higher penalty even if the earlier instance or instances of inaccurate information involved a different fact. If a child is killed while working and the child's permit lists the wrong age for the child, the civil penalty shall be \$10,000 for each instance. Otherwise, the civil penalties for inaccurate information on the applicable permit are as set forth in the following schedule:

<u>Instance</u>	<u>Penalty</u>
First	Warning letter
Second	\$100 civil penalty
Third	\$200 civil penalty
Fourth	\$500 civil penalty
Fifth	\$1,000 civil penalty
Sixth	\$2,500 civil penalty
Seventh	\$5,000 civil penalty
Eighth	\$7,500 civil penalty
Each additional instance	\$10,000 civil penalty

*b.* Rescinded IAB 8/28/19, effective 10/2/19.

*c. Working without a permit.* When a child is working without a required permit, and the day, time or occupation the child is working is also prohibited, the labor commissioner may assess civil penalties under this subrule and subrule 32.11(4) or subrule 32.11(5) as applicable. If a child is killed while working without a required permit, the civil penalty shall be \$10,000 for each instance. Otherwise, the civil penalties for working without a required permit are as set forth in the following schedule:

<u>Instance</u>	<u>Penalty</u>
First	\$250 civil penalty
Second	\$500 civil penalty
Third	\$1,000 civil penalty
Fourth	\$2,500 civil penalty
Fifth	\$5,000 civil penalty
Sixth	\$7,500 civil penalty
Each additional instance	\$10,000 civil penalty

**32.11(4) Hours violations.** If a child is killed while working at a prohibited time or for excessive hours, the civil penalty shall be \$10,000 for each instance. For other time or hour violations, the penalties set forth in this subrule shall be applied.

*a.* The civil penalties for working less than 15 minutes before or after an allowed time are as set forth in the following schedule:

<u>Instance</u>	<u>Penalty</u>
First	Warning letter
Second	\$100 civil penalty
Third	\$200 civil penalty
Fourth	\$500 civil penalty
Fifth	\$1,000 civil penalty
Sixth	\$2,500 civil penalty
Seventh	\$5,000 civil penalty
Eighth	\$7,500 civil penalty
Each additional instance	\$10,000 civil penalty

*b.* For any time or hours violation not described elsewhere in this subrule, the following civil penalty schedule shall apply:

<u>Instance</u>	<u>Penalty</u>
First	\$100 civil penalty
Second	\$250 civil penalty
Third	\$500 civil penalty
Fourth	\$1,000 civil penalty
Fifth	\$2,500 civil penalty
Sixth	\$5,000 civil penalty
Seventh	\$7,500 civil penalty
Each additional instance	\$10,000 civil penalty

**32.11(5) Occupation violations.**

*a.* If no serious illness or injury results from the work, the civil penalties for allowing or permitting a child to perform prohibited work are as set forth in the following schedule:

<u>Instance</u>	<u>Penalty</u>
First	\$500 civil penalty
Second	\$1,500 civil penalty
Third	\$2,500 civil penalty
Fourth	\$5,000 civil penalty
Fifth	\$7,500 civil penalty
Each additional instance	\$10,000 civil penalty

*b.* If a nonfatal but serious illness or injury results from the work, the civil penalties for allowing or permitting a child to perform prohibited work are as set forth in the following schedule:

<u>Instance</u>	<u>Penalty</u>
First	\$2,500 civil penalty
Second	\$5,000 civil penalty
Each additional instance	\$10,000 civil penalty

*c.* If a fatality results from the work, the civil penalty for allowing or permitting a child to perform prohibited work is \$10,000 for each instance.

**32.11(6) Penalty reduction factors.** Except for violations related to the death of a child while working, the labor commissioner shall reduce the penalty calculated pursuant to subrules 32.11(1) through 32.11(5) by the appropriate penalty reduction percentages set forth in this subrule. However, if

the labor commissioner requests information relevant to the penalty assessment and the employer does not provide responsive information, the labor commissioner shall not reduce the penalty.

*a. Penalty reduction for size of business.* The labor commissioner shall reduce a penalty by 25 percent if the employer has 25 or fewer employees. The labor commissioner shall reduce the penalty amount by 15 percent if the employer has 26 to 100 employees. The labor commissioner shall reduce the penalty amount by 5 percent if the employer has 101 to 250 employees.

*b. Penalty reduction for good faith.* The labor commissioner may reduce a penalty by 15 percent based upon evidence that the employer made a good faith attempt to comply with the requirements. If at any time the labor commissioner warned an employer in writing about a prohibited practice and a civil penalty is being assessed against the same employer for repeating the practice, the labor commissioner shall not reduce the penalty based on good faith.

*c. Penalty reduction for history.* The labor commissioner shall reduce a penalty by 10 percent if the labor commissioner has not assessed a civil penalty under this chapter within the past five years. If the labor commissioner has assessed a civil penalty under this chapter in the past five years but the civil penalty has not reached judicial or administrative finality, the civil penalty shall be reduced by 10 percent.

This rule is intended to implement Iowa Code section 92.22.

[ARC 8300B, IAB 11/18/09, effective 1/1/10; ARC 2134C, IAB 9/2/15, effective 10/7/15; ARC 4639C, IAB 8/28/19, effective 10/2/19]

### **875—32.12(92) Civil penalty procedures.**

**32.12(1) Notice of civil penalty.** The commissioner shall serve a notice of proposed civil penalty by certified mail or in a manner consistent with service of original notice under the Iowa Rules of Civil Procedure. The notice shall include the following:

- a.* A statement that the notice proposes a civil penalty assessment for violation of child labor laws.
- b.* Descriptions of the alleged violations including the provisions allegedly violated, the number of violations, and the proposed penalties.
- c.* A statement that the employer has the right to request a hearing by filing a notice of contest with the labor commissioner within 15 working days from the receipt of the notice of proposed civil penalty and that if a notice of contest is not timely filed, the proposed civil penalty will become final agency action.
- d.* A reference to the applicable procedural provisions.

**32.12(2) Notice of contest.** The civil penalty proposed by the labor commissioner shall become final agency action if the employer does not timely file a notice of contest. The filing date for a timely notice of contest shall be within 15 working days of the date the notice of proposed civil penalty was received by the employer. The notice of contest shall include the name, address, and telephone number of the employer's representative. If a notice of contest is filed by fax, the original shall be mailed to the labor commissioner.

**32.12(3) Contested case procedures.** Contested case procedures are set forth in 875—Chapter 1 and Iowa Code chapter 17A.

This rule is intended to implement Iowa Code section 92.22.

[ARC 8300B, IAB 11/18/09, effective 1/1/10; ARC 2134C, IAB 9/2/15, effective 10/7/15]

**875—32.13 to 32.16** Reserved.

**875—32.17(92) Definitions.** Rescinded ARC 2134C, IAB 9/2/15, effective 10/7/15.

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