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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

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Replace Chapter 15

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Replace Chapter 43 with Reserved Chapter 43

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Replace Chapter 1
Replace Chapter 3
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Replace Chapters 10 and 11
Replace Chapter 13
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Replace Chapter 79
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Replace Chapter 3

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Replace Chapter 164

Replace Chapter 520
Replace Chapter 607

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

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

DIVISION I
SALES PRACTICES

191—15.1(507B) Purpose. This chapter is intended to establish certain minimum standards and guidelines of conduct by identifying unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, as prohibited by Iowa Code chapter 507B.

191—15.2(507B) Definitions.

"Advertisement" for the purpose of these rules shall be material designed to create public interest in insurance or an insurer, or to induce the public to purchase, increase, modify, reinstate or retain a policy including:

1. Printed and published material, audio and visual material, and descriptive literature of an insurer or producer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards, computer on-line networks and similar displays; descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and sales talks, presentations, and material for use by producers.

2. However, for the purpose of these rules "advertisement" shall not include: communications or materials used within an insurer's own organization and not intended for dissemination to the public; communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate, or retain a policy; and a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged, provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

"Aftermarket crash parts" means replacement parts as defined in Iowa Code section 537B.4.

"Certificate" means a statement of the coverage and provisions of a policy of group accident and sickness insurance which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

"Duplicate Medicare supplement insurance" shall mean the sale or the attempt to knowingly sell to an individual a policy of insurance designed to supplement Medicare benefits as provided in The Health Insurance for the Aged Act, Title XVII of the Social Security Amendments of 1965 as then constituted or later amended when the individual is already insured under such a policy.

"Duplication" means policies of the same coverage type according to minimum standards classifications outlined in 191 IAC 36.6(514D) which overlap to the extent that a reasonable individual would not consider the ownership of the policies to be beneficial.

"Exception" for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

"Illustrated scale" shall mean a scale of nonguaranteed elements currently being illustrated that is not more favorable to the policyholder than the lesser of the disciplined current scale or the currently payable scale as defined in 191 IAC 14.4(507B).

"Institutional advertisement" means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of accident and sickness insurance, or the promotion of the insurer as a seller of accident and sickness insurance.

"Insurer" shall mean any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's, fraternal benefit society, and any other legal entity engaged in the business of insurance.

"Invitation to contract" means an advertisement for accident and sickness insurance that is neither an invitation to inquire nor an institutional advertisement.

"Invitation to inquire" means an advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss

for which benefits are payable. An invitation to inquire may not refer to cost but may contain the dollar amount of benefits payable and the period of time during which benefits are payable.

"Limitation" for the purpose of these rules shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

"Limited benefit health coverage" shall have the same meaning as defined in 191—subrule 36.6(10).

"Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including insurance producers and adjusters. "Person" shall also mean any corporation operating under the provisions of Iowa Code chapter 514 and any benevolent association as defined and operated under Iowa Code chapter 512A. For purposes of this chapter, corporations operating under the provisions of Iowa Code chapter 514 and Iowa Code chapter 512A shall be deemed to be engaged in the business of insurance.

"Policy" shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for insurance benefits.

"Preneed funeral contract or prearrangement" shall mean an agreement by or for an individual before the individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

"Producer" shall mean a person who solicits, negotiates, effects, procures, delivers, renews, continues or binds policies of insurance for risks residing, located or to be performed in this state.

"Prominently" or *"conspicuously"* means that the information to be disclosed will be presented in a manner that is noticeably set apart from other information or images in the advertisement.

"Reduction" for the purpose of these rules shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

"Twisting" shall mean any action by a producer or insurer to induce or attempt to induce any individual to lapse, forfeit, surrender, terminate, retain, assign, borrow, or convert a policy or an annuity in order that such individual procure another policy or annuity, when such action would operate to the overall detriment of the interests of the individual.

191—15.3(507B) Advertising.

15.3(1) *Form and content of advertisements.* The format and content of an advertisement shall be truthful and sufficiently complete and clear to avoid deception or the capacity or tendency to misrepresent or deceive. Whether an advertisement has a capacity or tendency to misrepresent or deceive shall be determined by the overall impression that the advertisement may be reasonably expected to create upon an individual in the segment of the public to which it is primarily directed and who has average education, intelligence and familiarity with insurance terminology for products in that market.

Information regarding exceptions, limitations, reductions and other restrictions required to be disclosed by this rule shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

15.3(2) *Prohibited terms and disclosure requirements for health insurance.*

a. No advertisement shall contain or use words or phrases such as "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

b. No advertisement shall contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

c. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free," "extra cash" and substantially similar

phrases which have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable an individual to make a profit from being hospitalized.

d. No advertisement shall use the words "only"; "just"; "merely"; "minimum" or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions."

e. An advertisement which refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

f. An advertisement may contain a brief description of coverage in an invitation to inquire so long as it is limited to a brief description of the loss for which benefits are payable. The brief description may also contain the dollar amount of benefits payable or the period of time during which benefits are payable, or both, but may not refer to the cost of the policy.

g. An advertisement for a policy which contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss shall prominently disclose the existence of such periods.

h. An invitation to inquire shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance agent or the company [whichever is applicable]."

15.3(3) *Prohibited terms in life insurance and annuity policies.* No advertisement for a life insurance or annuity policy shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," "retirement plan," or other similar term which has the capacity or tendency to mislead an insured or prospective insured to believe that the insurer is offering something other than an insurance policy or some benefit not available to other individuals of the same class and equal expectation of life. An advertisement shall not state that there are "no more premiums" or that premiums will "vanish" or "disappear" or use similar terms when such statement is not based on the guaranteed rates.

15.3(4) *Exclusions, limitations, exceptions and reductions.* Words and phrases used in an advertisement to describe policy exclusions, limitations, exceptions and reductions shall clearly, prominently and accurately indicate the negative or limited nature of the exclusions, limitations, exceptions and reductions.

An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or other policies providing benefits that are limited in nature shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS A LIMITED POLICY," "THIS POLICY PROVIDES LIMITED BENEFITS," or "THIS IS A CANCER-ONLY POLICY."

15.3(5) *Use of statistics.* An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

15.3(6) *Introductory, initial or special offers.*

a. An advertisement shall not directly or by implication represent that a policy is an introductory, initial or special offer, or that a person will receive advantages not available at a later date, or that the offer is available only to a specified group of persons, unless such is the fact.

b. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in each portion of the advertisement where the initial reduced premium appears. This paragraph shall not apply to annual renewable term policies.

15.3(7) *Testimonials or endorsements by third parties.*

a. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of these rules.

b. If the person making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial or endorsement, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements constitutes compensation and requires disclosure. This rule does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

c. An advertisement which states or implies that an insurer or an insurance product has been approved or endorsed by any person or other organizations must also disclose any proprietary or other relationship between the parties.

15.3(8) *Disparaging and incomplete comparisons and statements.* An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of noncomparable policies of other insurers, and shall not disparage other insurers, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of an insurer in the insurance business.

15.3(9) *Identity of insurer.*

a. The name of the actual insurer shall be clearly identified in all advertisements for a particular policy. An advertisement shall not use a trade name, insurance group designation, name of a parent company, name of a particular company division, service mark, slogan, symbol or other device which would have the capacity and tendency to misrepresent the true identity of an insurer.

b. No advertisement shall use any combination of words, symbols, or physical materials which by its content, phraseology, shape, color or other characteristics is so similar to combinations of words, symbols, or physical materials used by a municipal, state or federal agency that it would lead a reasonable individual to believe that the advertisement is approved, endorsed or accredited by an agency of the municipal, state, or federal government.

15.3(10) *Disclosure requirements for life insurance and annuities.*

a. An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed.

b. An advertisement for a policy with nonlevel premiums shall prominently describe the premium changes.

c. Dividends.

(1) An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends for an annuity are illustrated, the illustration must be based on the insurer's illustrated scale and must contain a statement that the illustration is not to be construed as a guarantee or estimate of dividends to be paid in the future.

(2) An advertisement shall not state or imply that the illustrated scale under a participating policy or pure endowments will be or can be sufficient at any future time to ensure, without the further payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains (1) what benefits or coverage would be provided at such time and (2) under what conditions this would occur.

d. An advertisement of a deferred annuity shall not state the net premium accumulation interest rate unless it discloses in close proximity thereto and with equal prominence the actual relationship between the gross and net premiums.

e. An advertisement that states the projected values of a policy must use the guaranteed interest rates in determining such projected values and, in addition, may show other projected values based on interest rates which comply with the illustrated scale. Any statements containing or based upon an interest rate higher than the guaranteed accumulation interest rates shall likewise set forth with equal prominence comparable statements containing or based upon the guaranteed accumulation interest rates. If the policy does not contain a provision for a guaranteed interest rate, any advertisement showing projected values must clearly state that the rates are not guaranteed. This subrule does not apply to an illustration or supplemental illustration subject to the provisions of the Life Illustrations Model Regulation, 191 IAC 14.

f. An advertisement or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such advertisement may be used for the purpose of demonstrating the cash flow pattern of a policy if such advertisement is accompanied by a statement disclosing that the advertisement does not recognize that, because of interest, a dollar in the future may not have the same value as a dollar at the time of the presentation.

g. An advertisement of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless they are also shown separately in close proximity thereto.

h. A statement regarding the use of life insurance cost indexes shall include an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

i. A life insurance cost index which reflects dividends or an equivalent level annual dividend shall be accompanied by a statement that it is based on the insurer's illustrated scale and is not guaranteed.

15.3(11) *Special offers.* Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had the recipient's eligibility for the insurance individually determined in advance when the advertisement is directed to all individuals in a group or to all individuals whose names appear on a mailing list.

15.3(12) *Disclosure requirement.* In an advertisement that is an invitation to contract for an accident and sickness insurance policy that is guaranteed renewable, cancelable or renewable at the option of the company, the advertisement shall disclose that the insurer has the right to increase premium rates if the policy so provides.

15.3(13) *Group or quasi-group implications.*

a. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and, as members, enjoy special rates or underwriting privileges, unless that is the fact.

b. This rule prohibits the solicitation of a particular class, such as governmental employees, by use of advertisements which state or imply that their class membership entitles the member to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

c. Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited.

d. An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct application required need not be on a separate document or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly,

the use of terms such as "enroll" or "join" to imply group or blanket insurance coverage is prohibited when that is not the fact.

e. Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact.

15.3(14) *Compliance with Medicare supplement advertising rules.* Insurers and producers shall comply with the Medicare supplement advertising rules set forth in 191—Chapter 37, Division II.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—15.4(507B) Life insurance cost and benefit disclosure requirements.

15.4(1) The definition of terms applicable to this rule and its appendices will be found in Appendix I.

15.4(2) Except as hereafter exempted, this rule shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. This rule shall apply to any insurer issuing life insurance contracts including fraternal benefit societies.

Unless otherwise specifically included, this rule shall not apply to:

a. Annuities.

b. Credit life insurance.

c. Group life insurance, except for disclosures relating to preneed funeral contracts or prearrangements as provided herein. These disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy.

d. Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

e. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

15.4(3) Prior to or at delivery of a life insurance policy, an insurer or producer shall provide the prospective purchaser the following:

a. A life insurance buyer's guide in the current form prescribed by the National Association of Insurance Commissioners or language approved by the commissioner of insurance, and

b. A policy summary as defined in Appendix I.

15.4(4) A policy summary is not required to include information available in the policy form or illustration. If an illustration subject to the provisions of 191 IAC 14, Life Insurance Illustrations Model Regulation, is used in the sale of a policy, delivery of a policy summary is not required. A policy summary may not include any element that is not guaranteed.

191—15.5(507B) Health insurance sales to individuals 65 years of age or older. The sale of duplicate Medicare supplement insurance is prohibited.

191—15.6(507B) Preneed funeral contracts or prearrangements.

15.6(1) *Advertising.* An advertisement for the solicitation or sale of a preneed funeral contract or prearrangement which is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

a. The fact that a life insurance policy or annuity contract is involved or being used to fund a prearrangement, and

b. The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

15.6(2) *Application.* Prior to accepting an application, initial premium or deposit, an insurer or producer must adequately disclose:

a. The relationship of the life insurance policy or annuity contract to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

b. The impact on the prearrangement of any:

(1) Changes in the life insurance policy or annuity contract including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds,

(2) Penalties to be incurred by the policyholder as a result of failure to make premium payments,

(3) Penalties to be incurred or moneys to be received as a result of cancellation or surrender of the life insurance policy or annuity contract;

c. A list of the merchandise and services which are supplied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

d. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy or annuity contract and the amount actually needed to fund the prearrangement;

e. Any penalties or restrictions including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

f. The fact that a sales commission or other form of compensation is being paid and, if so, the identity of the person to whom it is paid.

191—15.7(507B) Twisting prohibited. No insurer or producer shall engage in the act of twisting.

191—15.8(507B) Producer responsibilities.

15.8(1) *Required disclosures.* A producer shall inform the prospective purchaser, prior to commencing an insurance sales presentation, that the producer is acting as an insurance producer and inform the prospective purchaser of the producer's full name and the full name of the insurance company which the producer will represent in the insurance sales presentation. In sales situations in which a producer is not involved, the insurer shall identify its full name to a prospective purchaser.

15.8(2) *Improper sales tactics.*

a. Producers and insurers shall not employ any method of marketing or tactic which uses undue pressure, force, fright, threat, whether explicit or implied, to solicit the purchase of insurance.

b. A producer shall not:

(1) Execute a transaction for an insurance customer without authorization by the customer to do so; or

(2) Commit any act which shows that the producer has exerted undue influence over a person.

c. Producers and insurers shall not, without good cause:

(1) Fail or refuse to furnish any individual, upon reasonable request, information to which that individual is entitled, or to respond to a formal written request or complaint from any individual.

(2) Sell an insurance policy or rider to an individual which is a duplication of a policy or rider which the individual owns or for which the individual has applied at the time of the sale.

15.8(3) *Prohibited designations and fees.*

a. When an insurance producer is engaged only in the sale of insurance policies or annuities, the insurance producer shall not hold the producer out, directly or indirectly, to the public as a "financial planner," "investment adviser," "consultant," "financial counselor," or any other specialist solely engaged in the business of financial planning or giving advice relating to investments, insurance, real estate, tax matters or trust and estate matters. This provision does not preclude insurance producers who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance.

b. An insurance producer shall not engage in the business of financial planning without disclosing to the client prior to the execution of the agreement required by paragraph *"c"* or to the solicitation of the sale of a product or service that the producer is also an insurance producer and that a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case. The disclosure requirement under this paragraph may be met by including the disclosure in any disclosure required by federal or state securities law.

c. An insurance producer shall not charge fees other than commissions unless such fees are based upon a written agreement signed by the client in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the client at the time the agreement is signed by the client. The agreement must specifically state:

(1) The service for which the fee is to be charged;

(2) The amount of the fee to be charged or how it will be determined or calculated; and

(3) That the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

The insurance producer shall retain a copy of the agreement for not less than three years after completion of services, and a copy shall be available to the commissioner upon request.

d. Producers shall not charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies. This prohibition shall not apply to assigned risk policies and commercial property and casualty policies. Any additional fee that a producer intends to charge for assigned risk policies and commercial property and casualty policies must be fully disclosed to the insured.

e. Producers shall comply with rule 191—10.19(522B) in using senior-specific certifications and professional designations in the sale of life insurance and annuities.

15.8(4) *Suitability.* A producer shall not recommend to any person the purchase, sale or exchange of any life insurance policy, or any rider, endorsement or amendment thereto, without reasonable grounds to believe that the transaction or recommendation is not unsuitable for the person based upon reasonable inquiry concerning the person's insurance objectives, financial situation and needs, age and other relevant information known by the producer. For purposes of this subrule, when a producer recommends a group life insurance policy, "person" shall refer to the intended group policyowner.

15.8(5) *Prohibited acts.*

a. For purposes of this subrule:

"Gift" means a rendering of anything of value in return for which legal consideration of equal or greater value is not given and received.

"Immediate family" shall include parent, mother-in-law, father-in-law, spouse, former spouse, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, child and stepchild. In addition, "immediate family" shall include any other person who is supported, directly or indirectly, to a material extent by a producer.

"Loan" means an agreement to advance property, including but not limited to money, in return for the promise that payment will be made for use of the property.

b. A producer shall not:

(1) Solicit or accept, directly or indirectly, at any time, a personal loan from an insurance customer that in the aggregate exceeds $250, unless the customer is:

1. A bank, savings and loan, credit union or other recognized lending entity; or

2. A member of the producer's immediate family.

(2) Solicit or accept, directly or indirectly, at any time, a gift to the producer or to a member of the producer's immediate family from an insurance customer that in the aggregate exceeds $250, unless the customer is a member of the producer's immediate family. A gift to a member of the producer's immediate family shall be included in calculating the aggregate amount. A gift received by a member of the producer's immediate family from a customer that is not a member of the producer's immediate family in excess of the aggregate amount shall be deemed a violation of this subrule by the producer.

(3) Solicit or accept being named as a beneficiary, executor or trustee in a will, trust, insurance policy or annuity of a customer, unless the customer is a member of the producer's immediate family.

(4) Evade or otherwise violate the spirit of this subrule by terminating a producer relationship with an insurance customer for the purpose of soliciting or accepting a loan or a gift, or for the purpose of being named as a beneficiary, executor or trustee in a will, trust, insurance policy or annuity that the producer otherwise would have been prohibited from soliciting or accepting by this subrule. A producer will not be in violation of this subrule if the producer has made a bona fide termination of the producer

relationship with the insurance customer and has conducted no insurance or other business with the insurance customer for a period of three years.

c. Transactions which involve nominal interim ownership immediately precedent to transfer of ownership into a trust are exempt from this subrule.

191—15.9(507B) Right to return a life insurance policy or annuity (free look). The owner of an individual policy has the right, within ten days after receipt of a life insurance policy or annuity, to a free-look period. During this period, the policyowner may return the life insurance policy or annuity to the insurer at its home office, branch office, or to the producer through whom it was purchased. If so returned, the premium paid will be promptly refunded, the policy or annuity voided and the parties returned to the same position as if a policy or annuity had not been issued. If the transaction involved a replacement, the length of the free-look period will be determined according to 191—Chapter 16.

If the transaction involved a variable product, the amount to be refunded shall be determined according to the policy language. The calculations must comply with the relevant rule in either 191—Chapter 16, Replacement of Life Insurance and Annuities, or 191—Chapter 33, Variable Life Insurance Model Regulation.

191—15.10(507B) Uninsured/underinsured automobile coverage—notice required.

15.10(1) *Contents of notice.* Automobile insurance policies delivered in this state shall include a notice which contains and is limited to the following language:

NOTICE REGARDING UNINSURED/UNDERINSURED COVERAGE

Uninsured/underinsured coverage does not cover damage done to your vehicle. It provides benefits only for bodily injury caused by an uninsured or underinsured motorist. If you wish to be insured for damage done to your vehicle, you must have collision coverage. Please check your policy to make sure you have the coverage desired.

15.10(2) *Form of notice.* Notice may be provided on a separate form or may be stamped on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application but shall in no case be provided later than the time of delivery of the new policy. Insurers may inform applicants that the notice in this rule is required by the insurance division.

191—15.11(507B) Unfair discrimination.

15.11(1) *Sex discrimination.*

a. A contract shall not be denied to an individual based solely on that individual's sex or marital status. No benefits, terms, conditions or type of coverage shall be restricted, modified, excluded, or reduced on the basis of the sex or marital status of the insured or prospective insured except to the extent permitted under the Iowa Code or Iowa Administrative Code. An insurer may consider marital status for the purpose of defining individuals eligible for dependents' benefits. This subrule does not apply to group life insurance policies or group annuity contracts issued in connection with pension and welfare plans which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

b. Specific examples of practices prohibited by this subrule include, but are not limited to, the following:

(1) Denying coverage to individuals of one sex employed at home, employed part-time or employed by relatives when coverage is offered to individuals of the opposite sex similarly employed.

(2) Denying policy riders to persons of one sex when the riders are available to persons of the opposite sex.

(3) Denying a policy under which maternity coverage is available to an unmarried female when that same policy is available to a married female.

(4) Denying, under group contracts, dependent coverage to spouses of employees of one sex, when dependent coverage is available to spouses of employees of the opposite sex.

(5) Denying disability income coverage to employed members of one sex when coverage is offered to members of the opposite sex similarly employed.

(6) Treating complications of pregnancy differently from any other illness or sickness under the contract.

(7) Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one sex.

(8) Offering lower maximum monthly benefits to members of one sex than to members of the opposite sex who are in the same underwriting and occupational classification under a disability income contract.

(9) Offering more restrictive benefit periods and more restrictive definitions of disability to members of one sex than to members of the opposite sex in the same underwriting and occupational classifications under a disability income contract.

(10) Establishing different contract conditions based on gender which limit the benefit options a policyholder may exercise.

(11) Limiting the amount of coverage due to an insured's or prospective insured's marital status unless such limitation applies only to coverage for dependents and is uniformly applied to males and females.

c. When rates are differentiated on the basis of sex, an insurer must, upon the request of the commissioner of insurance, justify the rate differential in writing to the satisfaction of the commissioner. All rates shall be based on sound actuarial principles or a valid classification system and actual experience statistics, if available.

d. This subrule shall not affect the right of fraternal benefit societies to determine eligibility requirements for membership. If a fraternal benefit society does, however, admit members of both sexes, this subrule is applicable to the insurance benefits available to its members.

15.11(2) *Physical or mental impairment.* No contract, benefits, terms, conditions or type of coverage shall be denied, restricted, modified, excluded or reduced solely on the basis of physical or mental impairment of the insured or prospective insured except where based on sound actuarial principles or related to actual or reasonably anticipated experience. For purposes of this subrule, both blindness and partial blindness shall be considered a physical impairment.

15.11(3) *Income discrimination.* An insurer shall not refuse to issue, limit the amount or apply different rates to individuals of the same class in the sale of individual life insurance based solely upon the prospective insured's legal source or level of income, unless such action is based on sound actuarial principles or is related to actual or reasonably anticipated experience. The portion of this subrule pertaining to level of income does not:

a. Apply to the sale of disability income insurance of any kind or of any insurance designed to protect against economic loss due to a disruption in the regular flow of an individual's earned income;

b. Prohibit the sale of any insurance or annuity which is made available only to employees;

c. Prohibit basing the amount of insurance sold to an employee on a multiple or a percentage of the employee's salary or prohibit limiting availability to employees who have achieved a certain employment status as defined by the employer;

d. Prohibit insurers from providing life or health insurance as an incidental benefit through a qualified pension plan;

e. Prohibit insurers from applying suitability standards which include income as a factor in the sale of any life insurance or annuity products;

f. Prohibit insurers from establishing maximum or minimum amounts of insurance that will be issued to individuals so long as this is pursuant to a preexisting specialized marketing strategy which the insurer can demonstrate is related to the financial capacity of the insurer to write business or to bona fide transaction costs.

15.11(4) *Domestic abuse.* A contract shall not be denied to an individual based solely on the fact that such individual has been or is believed to have been a victim of domestic abuse as defined in Iowa Code section 236.2.

15.11(5) *Genetic information.* Any action by an insurer that is not in compliance with Title I of the Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233, 122 Stat. 881) shall be

considered an unfair trade practice and shall be subject to the penalties of Iowa Code chapter 507B and of these rules.

15.11(6) *Discrimination relating to children under the age of 19.* It is an unfair trade practice to:

a. Encourage individuals or groups to refrain from filing an application with an insurer for coverage for a child under the age of 19 because of the child's health status, claims experience, industry, occupation, or geographic location;

b. Encourage or direct children under the age of 19 to seek coverage from another insurer because of the child's health status, claims experience, industry, occupation, or geographic location; and

c. Encourage an employer to exclude an employee from coverage.

[**ARC 7796B**, IAB 5/20/09, effective 5/22/09; **ARC 7965B**, IAB 7/15/09, effective 8/19/09; **ARC 9498B**, IAB 5/4/11, effective 6/8/11]

191—15.12(507B) Testing restrictions of insurance applications for the human immunodeficiency virus.

15.12(1) *Written release.* No insurer shall obtain a test of any individual in connection with an application for insurance for the presence of an antibody to the human immunodeficiency virus unless the individual to be tested provides a written release on a form which contains the following information:

a. A statement of the purpose, content, use, and meaning of the test.

b. A statement regarding disclosure of the test results including information explaining the effect of releasing the information to an insurer.

c. A statement of the purpose for which test results may be used.

15.12(2) *Form.* A preapproved form is provided in Appendix II. An insurer wishing to utilize a form which deviates from the language in the appendix to these rules shall submit the form to the insurance division for approval. Any form containing, but not limited to, the language in the appendix shall be deemed approved.

15.12(3) *Test results.* A person engaged in the business of insurance who receives results of a positive human immunodeficiency virus (HIV) test in connection with an application for insurance shall report those results to a physician or alternative testing site of the applicant's or policyholder's choice or, if the applicant or policyholder does not choose a physician or alternative testing site to receive the results, to the Iowa department of public health.

191—15.13(507B) Records maintenance.

15.13(1) *Complaint and business records.*

a. An insurer shall maintain its books, records, documents and other business records in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner.

b. An insurer shall maintain a complete record of all the complaints received since the date of its last examination by the insurer's state of domicile or port-of-entry state. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. Appendix IV sets forth the minimum information required to be contained in the complaint record.

15.13(2) *Insurer's control over advertisements.* Every insurer shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements which explain a particular policy. All such advertisements, whether written, created, designed or presented by the insurer or its appointed producer, shall be the responsibility of the insurer whose particular policies are so advertised. As part of this requirement, each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its policies, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by the insurance division. All such advertisements shall be maintained for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

15.13(3) *Education and training materials.* Every insurer shall establish and maintain a system of control over the content and form of all material used by the insurer or any of its employees for the

recruitment, training, and education of producers in the sale of insurance. Upon request, copies of these materials shall be made available to the commissioner.

191—15.14(505,507B) Enforcement section—cease and desist and penalty orders.

15.14(1) If, after hearing, the commissioner determines that a person has engaged in an unfair trade practice in violation of these rules, an unfair method of competition, or an unfair or deceptive act or practice in violation of Iowa Code chapter 507B, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings and an order requiring the person to cease and desist from engaging in such method of competition, act or practice. The commissioner also may order one or more of the following:

a. Payment of a civil penalty of not more than $1,000 for each act or violation, but not to exceed an aggregate penalty of $10,000, unless the person knew or reasonably should have known that the actions were in violation of these rules or of Iowa Code chapter 507B, in which case the penalty shall be not more than $5,000 for each act or violation, but not to exceed an aggregate penalty of $50,000 in any one six-month period. If the commissioner finds that a violation of these rules or of Iowa Code chapter 507B was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer;

b. Suspension or revocation of an insurer's certificate of authority or the producer's license if the insurer or producer knew or reasonably should have known that it was in violation of these rules or of Iowa Code chapter 507B;

c. Payment of interest at the rate of 10 percent per annum if the commissioner finds that the insurer failed to pay interest as required under Iowa Code section 507B.4, subsection 12;

d. Full disclosure by the insurer of all terms and conditions of the policy to the policyowner;

e. Payment of the costs of the investigation and administrative expenses related to any act or violation. The commissioner may retain funds collected pursuant to any settlement, enforcement action, or other legal action authorized under federal or state law for the purpose of reimbursing costs and expenses of the division.

15.14(2) Any person who violates a cease and desist order of the commissioner while such order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or both of the following:

a. A civil penalty of not more than $10,000 for each and every act or violation.

b. Suspension or revocation of such person's license.

191—15.15 to **15.30** Reserved.

DIVISION II
CLAIMS

191—15.31(507B) General claims settlement guidelines. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

191—15.32(507B) Prompt payment of certain health claims. Effective July 1, 2002, the following provisions apply:

15.32(1) *Definitions and scope.*

a. For purposes of this rule, the following definitions apply:

"Circumstance requiring special treatment" means:

1. A claim that an insurer has a reasonable basis to suspect may be fraudulent or that fraud or a material misrepresentation may have occurred under the benefit certificate or policy or in obtaining such certificate or policy; or

2. A matter beyond the insurer's control, such as an act of God, insurrection, strike or other similar labor dispute, fire or power outage or, for a group-sponsored health plan, the failure of the sponsoring group to pay premiums to the insurer in a timely manner; or

3. Similar unique or special circumstances which would reasonably prevent an insurer from paying an otherwise clean claim within 30 days.

"Clean claim" means clean claim as defined in 2001 Iowa Acts, chapter 69, section 8(2b).

"Coordination of benefits for third-party liability" means a claim for benefits by a covered individual who has coverage under more than one health benefit plan.

"Insurer" means insurer as defined in 2001 Iowa Acts, chapter 69, section 7.

"Properly completed billing instrument" means:

1. In the case of a health care provider that is not a health care professional:

- The Health Care Finance Administration (HCFA) Form 1450, also known as Form UB-92, or similar form adopted by its successor Centers for Medicare/Medicaid Services (CMS) as adopted by the National Uniform Billing Committee (NUBC) with data element usage prescribed in the UB-92 National Uniform Billing Data Elements Specification Manual, or
- The electronic format for institutional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; or

2. In the case of a health care provider that is a health care professional:

- The HCFA Form 1500 paper form or its successor as adopted by the National Uniform Claim Committee (NUCC) and further defined by the NUCC in its implementation guide; or
- The electronic format for professional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; and

3. Any other information reasonably necessary for an insurer to process a claim for benefits under the benefit certificate or policy with the insured contract.

b. Scope. This subrule applies to claims submitted to an insurer as defined above on or after July 1, 2002, and is limited to policies issued, issued for delivery, or renewed in this state.

15.32(2) *Insurer duty to promptly pay claims and pay interest.*

a. Insurers subject to this subrule shall either accept and pay or deny a clean claim for health care benefits under a benefit certificate or policy issued by the insurer within 30 days after the insurer's receipt of such claim. A clean claim is considered to be paid on the date upon which a check, draft, or other valid negotiable instrument is written. Insurers shall implement procedures to ensure that these payments are promptly delivered.

b. Insurers or entities that administer or process claims on behalf of an insurer who fail to pay a clean claim within 30 days after the insurer's receipt of a properly completed billing instrument shall pay interest. Interest shall accrue at the rate of 10 percent per annum commencing on the thirty-first day after the insurer's receipt of all information necessary to establish a clean claim. Interest will be paid to the claimant or provider based upon who is entitled to the benefit payment.

c. Insurers shall have 30 days from the receipt of a claim to request additional information to establish a clean claim. An insurer shall provide a written or electronic notice to the claimant or health care provider if additional information is needed to establish a clean claim. The notice shall include a full explanation of the information necessary to establish a clean claim.

d. Effective January 1, 2003, when a claim involves coordination of benefits, an insurer is required to comply with the requirements of this subrule when that insurer's liability has been determined.

15.32(3) *Certain insurance products exempt.* Claims paid under the following insurance products are exempt from the provisions of this subrule: liability insurance, workers' compensation or similar insurance, automobile or homeowners insurance, medical payment insurance, disability income insurance, or long-term care insurance.

This rule is intended to implement 2001 Iowa Acts, chapter 69, section 8, and Iowa Code section 507B.4 as amended by 2001 Iowa Acts, chapter 69.

191—15.33(507B) Audit procedures for medical claims.

15.33(1) *Prohibitions.* This rule applies to all claims paid on or after January 1, 2002:

a. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim more than two years after the submission of the claim to the insurer. Nothing in this rule prohibits an insurer from requesting all records associated with the claim.

b. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim with a billed charge of less than $25.

15.33(2) *Standards.*

a. In auditing a claim, the insurer must make a reasonable effort to ensure that the audit is performed by a person or persons with appropriate qualifications for the type of audit being performed.

b. In auditing a claim, the auditor must use the coding guidelines and instructions that were in effect on the date the medical service was provided.

15.33(3) *Contents of audit request.* All correspondence regarding the audit of a claim must include the following information:

a. The name, address, telephone number and contact person of the insurer conducting the audit,

b. The name of the entity performing the audit if not the insurer,

c. The purpose of the audit, and

d. If included in the audit, the specific coding or billing procedure that is under review.

This rule is intended to implement Iowa Code section 507B.4, subsection 9, as amended by 2001 Iowa Acts, chapter 69.

191—15.34 to **15.40** Reserved.

191—15.41(507B) Claims settlement guidelines for property and casualty insurance. For purposes of this rule, "insurer" means property and casualty insurers.

15.41(1) An insurer shall fully disclose to first-party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.

15.41(2) Within 30 days after receipt by the insurer of properly executed proofs of loss, the first-party property claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing, and the claim file of the insurer shall contain documentation of the denial.

When there is a reasonable basis supported by specific information available for review by the commissioner that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subrule. However, the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

15.41(3) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, the insurer shall so notify the first-party claimant within 30 days after receipt of the proof of loss and give the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

When there is a reasonable basis supported by specific information available for review by the commissioner for suspecting that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subrule. However, the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

15.41(4) Insurers shall not fail to settle first-party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

15.41(5) No insurer shall make statements indicating that the rights of a third-party claimant may be impaired if a form or release, other than a release to obtain medical records, is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

15.41(6) The insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within 30 days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved, payments which are not in dispute under one

of the coverages and where the payee is known should be tendered within 30 days if such payment would terminate the insurer's known liability under that coverage.

15.41(7) No producer shall conceal from a first-party claimant benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

15.41(8) A claim shall not be denied on the basis of failure to exhibit property unless there is documentation of breach of the policy provisions to exhibit or cooperate in the claim investigation.

15.41(9) No insurer shall deny a claim based upon the failure of a first-party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition. An insurer may deny a claim if the claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.

15.41(10) No insurer shall indicate to a first-party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first-party claimant and the insurer as to coverage and amount payable under the contract.

15.41(11) No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.

191—15.42(507B) Acknowledgment of communications by property and casualty insurers. For purposes of this rule, "insurer" means property and casualty insurers.

15.42(1) Upon receiving notification of a claim, an insurer shall, within 15 days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgment is made by means other than in writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated.

15.42(2) Upon receipt of any inquiry from the Iowa insurance division regarding a claim, an insurer shall, within 21 days of receipt of such inquiry, furnish the division with an adequate response to the inquiry, in duplicate.

15.42(3) The insurer shall reply within 15 days to all pertinent communications from a claimant which reasonably suggest that a response is expected.

15.42(4) Upon receiving notification of claim, an insurer shall promptly provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subrule within 15 days of notification of a claim shall constitute compliance with subrule 15.42(1).

191—15.43(507B) Standards for settlement of automobile insurance claims.

15.43(1) Loss calculation and deviation guidelines.

a. Loss calculation. When the insurance policy provides for the adjustment and settlement of first-party automobile total losses on the basis of actual cash value or replacement with another automobile of like kind and quality, one of the following methods shall apply:

(1) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. All applicable taxes, license fees and other fees incident to the transfer of evidence of ownership of the automobile shall be paid by the insurer, at no cost to the insured, other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:

1. The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last 90 days to consumers in the local market area; or

2. The cost of two or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last 90 days to consumers when comparable automobiles are not available in the local market area; or

3. One of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area when the cost of comparable automobiles is not available; or

4. Any source for determining statistically valid fair market values that meet all of the following criteria:

- The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area.
- The source's database shall produce values for at least 85 percent of all makes and models for the last 15 model years taking into account the values of all major options for such vehicles.
- The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to ensure statistical validity.

(3) If the insurer is notified within 35 days of the receipt of the claim draft that the insured cannot purchase a comparable vehicle for such market value, the insured shall have a right of recourse. The insurer shall reopen its claim file and the following procedure(s) shall apply:

1. The insurer may locate a comparable vehicle by the same manufacturer, same or newer year, similar body style and similar options and price range for the insured for the market value determined by the insurer at the time of settlement. Any such vehicle must be available through a licensed dealer; or

2. The insurer shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this vehicle for the insured; or

3. The insurer may elect to offer a replacement in accordance with the provisions set forth in subrule 15.43(1); or

4. The insurer may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or a common law.

The insurer is not required to take action under this subrule if its documentation to the insured at the time of settlement included written notification of the availability and location of a specified and comparable vehicle of the same manufacturer, same or newer year, similar body style and similar options in as good or better condition as the total-loss vehicle which could have been purchased for the market value determined by the insurer before applicable deductions. The documentation shall include the vehicle identification number.

b. Deviation. When a first-party automobile total loss is settled on a basis which deviates from the methods described in paragraph *"a,"* the deviation must be supported by documentation giving particulars of the automobile's condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first-party claimant.

15.43(2) Where liability and damages are reasonably clear, an insurer shall not recommend that third-party claimants make claims under their own policies solely to avoid paying claims under the insurer's policy.

15.43(3) The insurer shall not require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

15.43(4) The insurer shall, upon the claimant's request, include the first-party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with

the first-party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses shall be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro-rata share of the allocated loss adjustment expense.

15.43(5) Vehicle repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate which the insured obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall (1) pay the difference between the written estimate and a higher estimate obtained by the insured, or (2) promptly provide the insured with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer designates only one or two such repair shops, the insurer shall ensure that the repairs are performed according to automobile industry standards. The insurer shall maintain documentation of all such communications.

15.43(6) When the amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

15.43(7) When the insurer elects to repair an automobile, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy, within a reasonable period of time.

15.43(8) Storage and towing. The insurer shall provide reasonable notice to an insured prior to termination of payment for automobile storage charges. The insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment. Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay all reasonable towing charges.

15.43(9) Betterment. Betterment deductions are allowable only if the deductions reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the vehicle. Betterment deductions must be measurable, itemized, specified as to dollar amount and documented in the claim file.

15.43(10) Diminished value. Rescinded IAB 4/28/04, effective 4/7/04.

191—15.44(507B) Standards for determining replacement cost and actual cost values.

15.44(1) *Replacement cost.* When the policy provides for the adjustment and settlement of first-party losses based on replacement cost, the following shall apply:

a. When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for betterment or any other cost except for the applicable deductible.

b. When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace as much of the item as is necessary to result in a reasonably uniform appearance within the same line of sight. This subrule applies to interior and exterior losses. Exceptions may be made on a case-by-case basis. The insured shall not bear any cost over the applicable deductible, if any.

15.44(2) *Actual cash value.*

a. When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine the actual cash value. "Actual cash value" means replacement cost of property at time of loss, less depreciation, if any. Alternatively, an insurer may use market value in determining actual cash value. Upon the insured's request, the insurer shall provide a copy of the claim file worksheet(s) detailing any and all deductions for depreciation.

b. In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of

actual cash value as set forth above is not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

15.44(3) *Applicability.* This rule does not apply to automobile insurance claims.

191—15.45(507B) Guidelines for use of aftermarket crash parts in motor vehicles.

15.45(1) *Identification.* All aftermarket crash parts supplied for use in this state shall comply with the identification requirements of Iowa Code section 537B.4.

15.45(2) *Like kind and quality.* An insurer shall not require the use of aftermarket crash parts in the repair of an automobile unless the aftermarket crash part is certified by a nationally recognized entity to be at least equal in kind and quality to the original equipment manufacturer part in terms of fit, quality and performance, or that the part complies with federal safety standards.

15.45(3) *Contents of notice.* Any automobile insurance policy delivered in this state that pays benefits based on the cost of aftermarket crash parts or that requires the insured to pay the difference between the cost of original equipment manufacturer parts and the cost of aftermarket crash parts shall include a notice which contains and is limited to the following language:

NOTICE—PAYMENT FOR AFTERMARKET CRASH PARTS

Physical damage coverage under this policy includes payment for aftermarket crash parts. If you repair the vehicle using more expensive original equipment manufacturer (OEM) parts, you may pay the difference. Any warranties applicable to these replacement parts are provided by the manufacturer or distributor of these parts rather than the manufacturer of your vehicle.

15.45(4) *Form of notice.* Notice may be provided on a separate form or may be printed prominently on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application, but shall in no case be provided later than the time of delivery of the new policy. Insurers may inform applicants that the insurance division requires the notice in this rule.

191—15.46 to **15.50** Reserved.

DIVISION III
DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

191—15.51(507B) Purpose. The purpose of these rules is to ensure the provision of meaningful information to the purchasers of small face amount life insurance policies. The rules in this division apply to all small face amount policies not exempted under rule 191—15.53(507B) that are issued on or after July 1, 2004.

191—15.52(507B) Definition. *"Small face amount policy"* means a life insurance policy or certificate with an initial face amount of $15,000 or less.

191—15.53(507B) Exemptions. These rules apply to all group and individual life insurance policies and certificates except:

1. Variable life insurance;
2. Individual and group annuity contracts;
3. Credit life insurance;
4. Group or individual policies of life insurance issued to members of an employer group or other permitted group when:
   - Every plan of coverage was selected by the employer or other group representative;
   - Some portion of the premium is paid by the group or through payroll deduction; and
   - Group underwriting or simplified underwriting is used; and
5. Policies and certificates where an illustration has been provided pursuant to the requirements of 191—Chapter 14.

191—15.54(507B) Disclosure requirements.

15.54(1) An insurer issuing a small face amount policy shall provide the disclosure included in Appendix IV if at any point in time over the term of the policy the cumulative premiums paid may exceed the face amount of the policy at that point in time. The required disclosure shall be provided to the policy owner or certificate holder no later than at the time the policy or certificate is delivered. The disclosure shall not be attached to the policy, but may be delivered with the policy.

15.54(2) If, for a particular policy form, the cumulative premiums may exceed the face amount for some demographic or benefit combination but not for all combinations, the insurer may choose to either:

a. Provide the disclosure only in those circumstances when the premiums may exceed the face amount; or

b. Provide the disclosure for all demographic and benefit combinations.

15.54(3) Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefit attributable to the riders.

191—15.55(507B) Insurer duties. The insurer and its producers shall have a duty to provide information to policyholders or certificate holders that ask questions about the disclosure statement.

191—15.56 to **15.60** Reserved.

DIVISION IV
ANNUITY DISCLOSURE REQUIREMENTS

191—15.61(507B) Purpose. The purpose of the rules in Division IV of this chapter is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and to foster consumer education. The rules specify the minimum information which must be disclosed, the method for disclosing it and the use and content of illustrations, if used, in connection with the sale of annuity contracts. The goal of these rules is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.
[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.62(507B) Applicability and scope. These rules apply to all annuities not exempted under this rule 191—15.62(507B) for which applications are taken on or after January 1, 2013, except that rule 191—15.66(507B) applies to all annuities not exempted under this rule 191—15.62(507B) which are in effect or for which applications are taken on or after January 1, 2013, and except that rule 191—15.67(507B) applies to all annuity contracts not exempted under this rule 191—15.62(507B) which are in effect on or after January 1, 2013. These rules apply to all group and individual annuity contracts and certificates except:

15.62(1) Immediate and deferred annuities that contain no nonguaranteed elements;

15.62(2) Annuities used to fund:

a. An employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

b. A plan described by Section 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

c. A governmental or church plan defined in Section 414 of the Internal Revenue Code or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

Notwithstanding this subrule 15.62(2), these rules shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make whether on a pretax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subrule, direct

solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

15.62(3) Structured settlement annuities;

15.62(4) Charitable gift annuities as defined in Iowa Code chapter 508F;

15.62(5) Nonregistered variable annuities issued exclusively to an accredited investor or qualified purchaser as those terms are defined by the Securities Act of 1933 (15 U.S.C. Section 77a et seq.), the Investment Company Act of 1940 (15 U.S.C. Section 80a-1 et seq.), or the regulations promulgated under either of those acts, and offered for sale and sold in a transaction that is exempt from registration under the Securities Act of 1933 (15 U.S.C. Section 77a et seq.); and

15.62(6) Transactions involving variable annuities and other registered products in compliance with Securities and Exchange Commission (SEC) rules and Financial Industry Regulatory Authority (FINRA) rules relating to disclosures and illustrations, provided that compliance with rule 191—15.64(507B) shall be required after January 1, 2015, unless, or until such time as, the SEC has adopted a summary prospectus rule or FINRA has approved for use a simplified disclosure form applicable to variable annuities or other registered products.

a. Notwithstanding this subrule 15.62(6), the delivery of the Buyer's Guide is required in sales of variable annuities and, when appropriate, in sales of other registered products.

b. Nothing in this subrule 15.62(6) shall limit the commissioner's ability to enforce the provisions of these rules or to require additional disclosure.

[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.63(507B) Definitions. For purposes of these rules:

"Buyer's Guide" means the National Association of Insurance Commissioners' approved Annuity Buyer's Guide.

"Contract owner" means the owner named in the annuity contract or the certificate holder in the case of a group annuity contract.

"Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after the contract is issued. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges, or elements of formulas used to determine any of these elements. These elements may be described as guaranteed but not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

"Funding agreement" means an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.

"Generic name" means a short title descriptive of the annuity contract for which application is made or an illustration is prepared, such as "single premium deferred annuity."

"Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges, or elements of formulas used to determine any of these elements, that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

"Illustration" means a personalized presentation or depiction that is prepared for and provided to an individual consumer and that includes nonguaranteed elements of an annuity contract over a period of years.

"Market value adjustment" or *"MVA"* is a positive or negative adjustment that may be applied to the account value or cash value of the annuity upon withdrawal, surrender, contract annuitization or death benefit payment based either on the movement of an external index or on the company's current guaranteed interest rate being offered on new premiums or new rates for renewal periods, if that withdrawal, surrender, contract annuitization or death benefit payment occurs at a time other than on a specified guaranteed benefit date.

"Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges or elements of formulas used to determine any of these elements, that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

"Structured settlement annuity" means a "qualified funding asset" as defined in Section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under Section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.64(507B) Standards for the disclosure document and Buyer's Guide.

15.64(1) *Delivery methods.* The documents required under this rule may be delivered as follows:

a. When an application for an annuity contract is taken in a face-to-face meeting, the applicant shall be given at or before the time of application both the disclosure document described in rule 191—15.65(507B) and the Buyer's Guide, if any.

b. When an application for an annuity contract is taken by means other than a face-to-face meeting, the applicant shall be sent both the disclosure document and the Buyer's Guide no later than five business days after the completed application is received by the insurer.

c. When an application is received as a result of direct solicitation through the mail:

(1) Providing a Buyer's Guide in a mailing inviting prospective applicants to apply for an annuity contract shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five business days after receipt of the application.

(2) Providing a disclosure document in a mailing inviting a prospective applicant to apply for an annuity contract shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

d. When an application is received via the Internet:

(1) Taking reasonable steps to make the Buyer's Guide available for viewing and printing on the insurer's Web site shall be deemed to satisfy the requirement that the Buyer's Guide be provided no later than five business days after receipt of the application.

(2) Taking reasonable steps to make the disclosure document available for viewing and printing on the insurer's Web site shall be deemed to satisfy the requirement that the disclosure document be provided no later than five business days after receipt of the application.

15.64(2) *Free Buyer's Guide.* A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the Iowa insurance division for a free Buyer's Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free Buyer's Guide.

15.64(3) *Free-look period.* When the Buyer's Guide and disclosure document are not provided at or before the time of application, a free-look period of no less than 15 days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under state law or rule.

[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.65(507B) Content of disclosure documents.

15.65(1) At a minimum, the following information shall be included in the disclosure document required to be provided under these rules:

a. The generic name of the contract, the company product name, if different, and form number and the fact that it is an annuity;

b. The insurer's legal name, physical address, Web site address and telephone number;

c. A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate, including but not limited to:

(1) The guaranteed and nonguaranteed elements of the contract, and their limitations, if any, including for fixed indexed annuities, the elements used to determine the index-based interest, such as the participation rates, caps or spread, and an explanation of how they operate;

(2) An explanation of the initial crediting rate, or for fixed indexed annuities, an explanation of how the index-based interest is determined, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(3) Periodic income options both on a guaranteed and nonguaranteed basis;

(4) Any value reductions caused by withdrawals from or surrender of the contract;

(5) How values in the contract can be accessed;

(6) The death benefit, if available, and how it will be calculated;

(7) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(8) Impact of any rider including, but not limited to, a guaranteed living benefit or a long-term care rider;

d. Specific dollar amount or percentage charges and fees, listed with an explanation of how they apply; and

e. Information about the current guaranteed rate or indexed crediting rate formula, if applicable, for new contracts that contains a clear notice that the rate is subject to change.

15.65(2) Insurers shall define terms used in the disclosure statement in language that facilitates understanding by a typical individual within the segment of the public to which the disclosure statement is directed.

[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.66(507B) Standards for annuity illustrations.

15.66(1) An insurer or producer may elect to provide a consumer an illustration at any time, provided that the illustration is in compliance with this rule and:

a. Is clearly labeled as an illustration;

b. Includes a statement referring consumers to the disclosure document and Buyer's Guide provided to them at time of purchase for additional information about their annuity; and

c. Is prepared by the insurer or third party using software that is authorized by the insurer prior to its use, provided that the insurer maintains a system of control over the use of illustrations.

15.66(2) An illustration furnished an applicant for a group annuity contract or contracts issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.

15.66(3) The illustration shall not be provided unless accompanied by the disclosure document referenced in rules 191—15.64(507B) and 191—15.65(507B).

15.66(4) When an illustration is used, the illustration shall not:

a. Describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;

b. State or imply that the payment or amount of nonguaranteed elements is guaranteed; or

c. Be incomplete.

15.66(5) Costs and fees of any type shall be individually noted and explained in the illustration.

15.66(6) An illustration shall conform to the following requirements:

a. The illustration shall be labeled with the date on which it was prepared;

b. Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled "page 4 of 7 pages");

c. The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;

d. If the age of the proposed insured is shown as a component of the tabular detail, the age shown shall be issue age plus the numbers of years the contract is assumed to have been in force;

e. The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;

f. Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement

indicating the nature of the rider benefits or the contract features and indicating whether or not they are included in the illustration;

g. Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled as guaranteed;

h. The nonguaranteed elements underlying the nonguaranteed illustrated values shall be no more favorable than current nonguaranteed elements and shall not include any assumed future improvement of such elements. Additionally, nonguaranteed elements used in calculating nonguaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;

i. In determining the nonguaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent 10 calendar years; one to reflect the historical performance of the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the least index value growth (the "low scenario"); one to reflect the historical performance of the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the most index value growth (the "high scenario"). The following requirements apply:

(1) The most recent 10 calendar years and the last 20 calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;

(2) If any index utilized in determination of an account value has not been in existence for at least 10 calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least 10 calendar years, the allocation to such indexed account shall be assumed to be zero;

(3) If any index utilized in determination of an account value has been in existence for at least 10 calendar years but less than 20 calendar years, the 10-calendar-year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;

(4) The nonguaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the nonguaranteed index-based interest rate shall be no more favorable than the corresponding current elements;

(5) If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:

1. The allocation used in the illustration shall be the same for all three scenarios; and

2. The 10-calendar-year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option;

(6) The geometric mean annual effective rate of the account value growth over the 10-calendar-year period shall be shown for each scenario;

(7) If the most recent 10-calendar-year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subrule 15.66(8), the most recent 10-calendar-year historical period experience of the index shall be used for each subsequent 10-calendar-year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;

(8) The low and high scenarios:

1. Need not show surrender values (if different than account values);

2. Shall not extend beyond 10 calendar years (and therefore are not subject to the requirements of subrule 15.66(8) beyond subparagraph 15.66(8)*"a"*(1)); and

3. May be shown on a separate page. A graphical presentation shall also be included comparing the movement of the account value over the 10-calendar-year period for the low scenario, the high scenario and the most recent 10-calendar-year scenario; and

(9) The low and high scenarios should reflect the irregular nature of the index performance and should trigger every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied

may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;

j. The guaranteed elements, if any, shall be shown before corresponding nonguaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the nonguaranteed elements (e.g., "see page 1 for guaranteed elements");

k. The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;

l. The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest and application of any market value adjustment, as applicable;

m. Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;

n. Any illustration of nonguaranteed elements shall be accompanied by a statement indicating that:

(1) The benefits and values are not guaranteed;

(2) The assumptions on which they are based are subject to change by the insurer; and

(3) Actual results may be higher or lower;

o. Illustrations based on nonguaranteed credited interest and nonguaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and nonguaranteed participation rates, caps or spreads for fixed indexed annuities;

p. The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;

q. Illustrations shall be concise and easy to read;

r. Key terms shall be defined and then used consistently throughout the illustration;

s. Illustrations shall not depict values beyond the maximum annuitization age or date;

t. Annuitization benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and

u. Illustrations shall show both annuity income rates per $1000.00 and the dollar amounts of the periodic income payable.

15.66(7) An annuity illustration shall include a narrative summary that includes the following unless provided at the same time in a disclosure document:

a. A brief description of any contract features, riders or options, whether guaranteed or nonguaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the contract.

b. A brief description of any other optional benefits or features that are selected, but not shown in the illustration and the impact they have on the benefits and values of the contract.

c. Identification and a brief definition of column headings and key terms used in the illustration.

d. A statement containing in substance the following:

(1) For other than fixed indexed annuities:

This illustration assumes the annuity's current nonguaranteed elements will not change. It is likely that they **will** change and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are **not** guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information.

(2) For fixed indexed annuities:

This illustration assumes the index will repeat historical performance and that the annuity's current nonguaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, will not change. It is likely that the index **will**

not repeat historical performance, the nonguaranteed elements **will** change, and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are **not** guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information.

e. Additional explanations as follows:

(1) Minimum guarantees shall be clearly explained;

(2) The effect on contract values of contract surrender prior to maturity shall be explained;

(3) Any conditions on the payment of bonuses shall be explained;

(4) For annuities sold as an IRA or as a qualified plan or in another arrangement subject to the required minimum distribution (RMD) requirements of the Internal Revenue Code, the effect of RMDs on the contract values shall be explained;

(5) For annuities with recurring surrender charge schedules, a clear and concise explanation of what circumstances will cause the surrender charge to recur shall be included; and

(6) A brief description of the types of annuity income options available shall be explained, including:

1. The earliest or only maturity date for annuitization (as the term is defined in the contract);

2. For contracts with an optional maturity date, the periodic income amount for at least one of the annuity income options available based on the guaranteed rates in the contract, at the later of age 70 or 10 years after issue, but in no case later than the maximum annuitization age or date in the contract;

3. For contracts with a fixed maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract at the fixed maturity date; and

4. The periodic income amount based on the currently available periodic income rates for the annuity income option in numbered paragraph 15.66(7)*"e"*(6)"2" or "3," if desired.

15.66(8) Following the narrative summary, an illustration shall include a numeric summary which shall include, at minimum, numeric values at the following durations:

a. Either:

(1) The first 10 contract years; or

(2) The surrender charge period if longer than 10 years, including any renewal surrender charge period;

b. Every tenth contract year up to the later of 30 years or age 70; and

c. Either:

(1) The required annuitization age; or

(2) The required annuitization date.

15.66(9) If the annuity contains a market value adjustment, hereafter MVA, all of the following provisions apply to the illustration (Appendix V provides an illustration of an annuity containing an MVA that addresses paragraphs 15.66(9)*"a"* through *"f"* below):

a. The MVA shall be referred to as such throughout the illustration.

b. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the value available upon surrender.

c. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the death benefit.

d. A statement, containing in substance the following, shall be included:

When you make a withdrawal, the amount you receive may be increased or decreased by a Market Value Adjustment (MVA). If interest rates on which the MVA is based go up after you buy your annuity, the MVA likely will decrease the amount you receive. If interest rates go down, the MVA will likely increase the amount you receive.

e. Illustrations shall describe both the upside and the downside aspects of the contract features relating to the market value adjustment.

f. The illustrative effect of the MVA shall be shown under at least one positive and one negative scenario. This demonstration shall appear on a separate page and be clearly labeled that it is information demonstrating the potential impact of an MVA.

g. Actual MVA floors and ceilings as listed in the contract shall be illustrated.

h. If the MVA has significant characteristics not addressed by paragraphs 15.66(9)*"a"* through *"f,"* the effect of such characteristics shall be shown in the illustration.

15.66(10) A narrative summary for a fixed indexed annuity illustration also shall include the following unless provided at the same time in a disclosure document:

a. An explanation, in simple terms, of the elements used to determine the index-based interest, including, but not limited to, the following elements:

(1) The index(es) which will be used to determine the index-based interest;

(2) The indexing method – such as point-to-point, daily averaging, monthly averaging;

(3) The index term – the period over which indexed-based interest is calculated;

(4) The participation rate, if applicable;

(5) The cap, if applicable; and

(6) The spread, if applicable;

b. The narrative shall include an explanation, in simple terms, of how index-based interest is credited in the indexed annuity;

c. The narrative shall include a brief description of the frequency with which the company can reset the elements used to determine the indexed-based credits, including the participation rate, the cap, and the spread, if applicable; and

d. If the product allows the contract holder to make allocations to declared-rate segment, then the narrative shall include a brief description of:

(1) Any options to make allocations to a declared-rate segment, both for new premiums and for transfers from the indexed-based segments; and

(2) Differences in guarantees applicable to the declared-rate segment and the indexed-based segments.

15.66(11) A numeric summary for a fixed indexed annuity illustration shall include, at a minimum, the following elements:

a. The assumed growth rate of the index in accordance with paragraph 15.66(6)*"i"*;

b. The assumed values for the participation rate, cap and spread, if applicable; and

c. The assumed allocation between indexed-based segments and declared-rate segment, if applicable, in accordance with paragraph 15.66(6)*"i."*

15.66(12) If the contract is issued other than as applied for, a revised illustration conforming to the contract as issued shall be sent with the contract, except that nonsubstantive changes including, but not limited to, changes in the amount of expected initial or additional premiums and any changes in amounts of exchanges pursuant to Section 1035 of the Internal Revenue Code, rollovers or transfers, which do not alter the key benefits and features of the annuity as applied for will not require a revised illustration unless requested by the applicant.

[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.67(507B) Report to contract owners. For annuities in the payout period that include nonguaranteed elements and for deferred annuities in the accumulation period, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

15.67(1) The beginning and ending date of the current report period;

15.67(2) The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

15.67(3) The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and

15.67(4) The amount of outstanding loans, if any, as of the end of the current report period.

[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.68(507B) Penalties. In addition to any other penalties provided by the laws of this state, an insurer or producer that violates a requirement of these rules shall be guilty of a violation of Iowa Code chapter 507B.
[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.69(507B) Severability. If any provision of these rules or their application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the rule and its application to other persons or circumstances shall not be affected.
[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.70 and **15.71** Reserved.

DIVISION V
SUITABILITY IN ANNUITY TRANSACTIONS

191—15.72(507B) Purpose. The purpose of these rules is to require insurers to establish a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the times of the transactions are appropriately addressed.
[**ARC 8934B**, IAB 7/14/10, effective 1/1/11; **ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.73(507B) Applicability and scope.

15.73(1) These rules shall apply to any recommendation to purchase, exchange or replace an annuity made to a consumer on or after January 1, 2011, by an insurance producer, or by an insurer where no producer is involved, that results in the purchase, exchange or replacement recommended.

15.73(2) Unless otherwise specifically included, this rule shall not apply to transactions involving:

a. Direct-response solicitations where there is no recommendation based on information collected from the consumer pursuant to these rules.

b. Contracts used to fund the following:

(1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(2) A plan described by Section 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC) if established or maintained by an employer;

(3) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under Section 457 of the IRC;

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(5) Settlements or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(6) Formal prepaid funeral contracts.
[**ARC 8934B**, IAB 7/14/10, effective 1/1/11; **ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.74(507B) Definitions. For purposes of this division:

"Annuity" means an annuity that is an insurance product under state law, individually solicited, whether the product is classified as an individual or group annuity.

"Continuing education credit" or *"CE credit"* means one credit as defined in rule 191—11.2(505,522B).

"Continuing education provider" or *"CE provider"* means a CE provider as defined in rule 191—11.2(505,522B).

"FINRA" means the Financial Industry Regulatory Authority or a succeeding agency.

"Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.

"Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

"Recommendation" means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase, exchange or replacement of an annuity in accordance with that advice.

"Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that, by reason of the transaction, an existing policy or contract has been or is to be:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;
2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value; or
5. Used in a financed purchase.

"Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including the following:

1. Age;
2. Annual income;
3. Financial situation and needs, including the financial resources used for the funding of the annuity;
4. Financial experience;
5. Financial objectives;
6. Intended use of the annuity;
7. Financial time horizon;
8. Existing assets, including investment and life insurance holdings;
9. Liquidity needs;
10. Liquid net worth;
11. Risk tolerance; and
12. Tax status.

[**ARC 8934B**, IAB 7/14/10, effective 1/1/11; **ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.75(507B) Duties of insurers and of insurance producers.

15.75(1) In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance products and as to the consumer's financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

a. The consumer has been reasonably informed of various features of the recommended annuity, such as: the potential surrender period and surrender charge; potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity; mortality and expense fees; investment advisory fees; potential charges for and features of riders; limitations on interest returns; insurance and investment components; and market risk;

b. The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization, death benefit, or living benefit;

c. The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on the consumer's suitability information; and

d. In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable, including taking into consideration whether:

(1) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death benefit, living benefit, or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(2) The consumer would benefit from product enhancements and improvements; and

(3) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

15.75(2) Prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain the consumer's suitability information.

15.75(3) Except as permitted under subrule 15.75(4), an insurer shall not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer's suitability information.

15.75(4) Exceptions.

a. Except as provided under paragraph 15.75(4)*"b,"* neither an insurance producer, nor an insurer, shall have any obligation to a consumer under subrule 15.75(1) or 15.75(3) related to any annuity transaction if:

(1) No recommendation is made;

(2) A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;

(3) A consumer refuses to provide relevant suitability information and the annuity transaction is not recommended; or

(4) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the insurance producer.

b. An insurer's issuance of an annuity subject to paragraph 15.75(4)*"a"* shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

15.75(5) An insurance producer or, where no insurance producer is involved, the responsible insurer representative, shall at the time of sale:

a. Make a record of any recommendation subject to subrule 15.75(1);

b. Obtain a customer-signed statement documenting a customer's refusal to provide suitability information, if any; and

c. Obtain a customer-signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

15.75(6) An insurer's duty to supervise.

a. An insurer shall establish a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with rules 191—15.72(507B) through 191—15.78(507B) including, but not limited to, the following:

(1) The insurer shall maintain reasonable procedures to inform its insurance producers of the requirements of these rules and shall incorporate the requirements of these rules into relevant insurance producer training manuals;

(2) The insurer shall establish standards for insurance producer product training and shall maintain reasonable procedures to require its insurance producers to comply with the requirements of rule 191—15.76(507B);

(3) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its insurance producers;

(4) The insurer shall maintain procedures for review of each recommendation prior to issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other

means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(5) The insurer shall maintain reasonable procedures to detect recommendations that are not suitable. These procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures or by confirming suitability information after issuance or delivery of the annuity; and

(6) The insurer shall annually provide a report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

b. Third-party supervisor.

(1) Nothing in this subrule restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under paragraph 15.75(6)*"a."* An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to rule 191—15.73(507B) regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph 15.75(6)*"b"*(2).

(2) An insurer's supervision system under paragraph 15.75(6)*"a"* shall include supervision of contractual performance under this subrule including, but not limited to, the following:

1. Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

2. Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

c. An insurer is not required to include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer.

15.75(7) An insurance producer shall not dissuade, or attempt to dissuade, a consumer from:

a. Truthfully responding to an insurer's request for confirmation of suitability information;

b. Filing a complaint; or

c. Cooperating with the investigation of a complaint.

15.75(8) Compliance with FINRA.

a. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under these rules. This subrule applies to FINRA member broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision are similar to those applied to variable annuity sales. However, nothing in this subrule shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

b. For paragraph 15.75(8)*"a"* to apply, an insurer shall:

(1) Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and

(2) Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

[**ARC 8934B**, IAB 7/14/10, effective 1/1/11; **ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.76(507B) Insurance producer training.

15.76(1) An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer's standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this subrule.

15.76(2) Training required.

a. One-time course.

(1) An insurance producer who engages in the sale of annuity products shall complete a one-time four-credit training course approved by the Iowa insurance division and provided by an education provider approved by the insurance division.

(2) Insurance producers may not engage in the sale of annuities until the annuity training course required under this rule has been completed.

b. The minimum length of the training required under this rule shall be sufficient to qualify for at least four CE credits, but may be longer.

c. The training required under this rule shall include information on the following topics:

(1) The types of annuities and various classifications of annuities;

(2) Identification of the parties to an annuity;

(3) How fixed, variable and indexed annuity contract provisions affect consumers;

(4) The application of income taxation of qualified and nonqualified annuities;

(5) The primary uses of annuities;

(6) Appropriate sales practices; and

(7) Replacement and disclosure requirements.

d. Providers of courses intended to comply with this rule shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

e. A provider of an annuity training course intended to comply with this rule shall register as a CE provider in this state and comply with the rules and guidelines applicable to insurance producer continuing education courses as set forth in 191—Chapter 11.

f. Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with 191—Chapter 11.

g. Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with 191—Chapter 11.

h. Satisfaction of the training requirements of another state that are substantially similar to the provisions of this subrule shall be deemed to satisfy the training requirements of this subrule in this state.

i. An insurer shall verify that an insurance producer has completed the annuity training course required under this subrule before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subrule by obtaining certificates of completion of the training course or obtaining reports provided by Iowa insurance commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved continuing education providers.

[**ARC 8934B**, IAB 7/14/10, effective 1/1/11; **ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.77(507B) Compliance; mitigation; penalties.

15.77(1) An insurer is responsible for compliance with this regulation. If a violation occurs, either because of the action or inaction of the insurer or its insurance producer, the commissioner may order:

a. An insurer to take reasonably appropriate corrective action for any consumer harmed by the insurer's, or by its insurance producer's, violation of the rules of this division;

b. A general agency, independent agency or the insurance producer to take reasonably appropriate corrective action for any consumer harmed by the insurance producer's violation of the rules of this division; and

c. Appropriate penalties and sanctions.

15.77(2) Any applicable penalty under Iowa Code chapter 507B for a violation of the rules in Division V of this chapter may be reduced or eliminated if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

[**ARC 8934B**, IAB 7/14/10, effective 1/1/11; **ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.78(507B) Record keeping.

15.78(1) Insurers, general agents, independent agencies, and insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for ten years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

15.78(2) Records required to be maintained by this rule may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

[**ARC 8934B**, IAB 7/14/10, effective 1/1/11; **ARC 0035C**, IAB 3/7/12, effective 4/11/12]

191—15.79 Reserved.

DIVISION VI
INDEXED PRODUCTS TRAINING REQUIREMENT

191—15.80(507B,522B) Purpose. The purpose of the rules in this division is to require certain specific minimum training for insurance producers who wish to sell indexed annuities or indexed life insurance in Iowa. This additional training is necessary due to the complex nature of these indexed products and to ensure that insurance producers are able to determine whether an indexed product is suitable for a consumer and are able to adequately explain to a consumer how the indexed product works. The ultimate goal of these rules is to ensure that purchasers of indexed products understand basic features of the indexed products. The rules in this division apply to all indexed products sold on or after January 1, 2008.

191—15.81(507B,522B) Definitions. For the purpose of this division:

"CE credit" means one continuing education "credit" as defined in 191—Chapter 11.

"CE provider" means any individual or entity that is approved to offer continuing education courses in Iowa pursuant to 191—Chapter 11.

"Indexed products" means all fixed indexed life insurance and fixed indexed annuity products.

"Insurer" means an insurance company admitted to do business in Iowa which sells indexed products in Iowa.

"Producer" means a person required to obtain an insurance license under Iowa Code chapter 522B.

191—15.82(507B,522B) Special training required. A producer who wishes to sell indexed products in Iowa shall complete at least one four-credit indexed products training course, as described in this division, prior to providing any advice or making any sales presentation concerning an indexed product.

191—15.83(507B,522B) Conduct of training course.

15.83(1) The indexed products training shall include information on all topics listed in the most recent version of the indexed products training outline available at the division's Web site, www.iid.state.ia.us.

15.83(2) CE providers of indexed products training shall cover all topics listed in the indexed products training outline and, within the time allotted for the required topics, shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

15.83(3) The minimum length of the indexed products training must be sufficient to qualify for at least four CE credits, but may be longer.

15.83(4) To satisfy the requirements of subrules 15.83(1), 15.83(2) and 15.83(3), an indexed products training course shall be filed, approved and conducted according to the rules and guidelines applicable to insurance producer continuing education courses as set forth in 191—Chapter 11.

15.83(5) Indexed products training courses may be conducted and completed by classroom or self-study methods according to the rules in 191—Chapter 11.

15.83(6) CE providers of indexed products training shall comply with the reporting requirements as set forth in 191—Chapter 11.

15.83(7) CE providers of indexed products training shall issue certificates of completion according to the rules in 191—Chapter 11.

15.83(8) A producer may use the CE credits completed under the indexed products training requirement to meet the producer's continuing education requirement under 191—Chapter 11.

191—15.84(507B,522B) Insurer duties.

15.84(1) Each insurer shall establish a system to verify which of its appointed insurance producers have completed one training course on indexed products as required in this division.

15.84(2) An insurer shall verify that a producer has completed the required indexed products training before allowing the producer to sell an indexed product for that insurer.

15.84(3) For insurance producers under contract with or employed by a broker-dealer, general agent or independent agency, an insurer may enter into a contract with the broker-dealer, general agent or independent agency to establish and maintain a system of verification as required by subrule 15.84(1) with respect to those insurance producers. In such circumstances, the insurer shall make reasonable inquiry to ensure that the broker-dealer, general agent or independent agency is performing the functions required under subrules 15.84(1) and 15.84(2).

191—15.85(507B,522B) Verification of training. Insurers, producers and third-party contractors may verify a producer's completion of the indexed products training by accessing the division's Web site at www.iid.state.ia.us.

191—15.86(507B,522B) Penalties.

15.86(1) Insurers and third-party contractors that violate the rules of this division are subject to penalty under Iowa Code chapter 507B.

15.86(2) Producers who violate the rules of this division are subject to penalty under Iowa Code chapters 507B and 522B.

15.86(3) Continuing education providers that fail to follow the requirements of the rules of this division and the conduct requirements of 191—Chapter 11 are subject to penalty under 191—Chapter 11 and Iowa Code chapters 507B and 522B.

191—15.87(507B,522B) Compliance date.

15.87(1) A producer who provides advice or makes a sales presentation regarding an indexed product on or after January 1, 2008, shall have completed the indexed products training required by this division.

15.87(2) An Iowa-licensed insurer shall verify that, prior to the sale of any indexed products on or after January 1, 2008, any producer appointed by the insurer has completed the indexed products training required by this division.

Appendix I
LIFE INSURANCE COST AND BENEFIT DISCLOSURE

Definitions.

"Annual premium" for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

"Cash dividend" means dividends which can be applied toward payment of gross premiums which comply with the illustrated scale.

"Equivalent level annual dividend" is calculated by applying the following steps:

1. Accumulate the annual cash dividends at 5 percent interest compounded annually to the end of the tenth and twentieth policy years.
2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
3. Divide the results of paragraph "2" by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

"Equivalent level death benefit" of a policy or term life insurance rider is an amount calculated as follows:

1. Accumulate the guaranteed amount payable upon death, regardless of the cause of death other than suicide, or other specifically enumerated exclusions, at the beginning of each policy year for 10 and 20 years at 5 percent interest compounded annually to the end of the tenth and twentieth policy years respectively.
2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

"Generic name" means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

"Life insurance net payment cost index." The life insurance net payment cost index is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

"Life insurance surrender cost index." The life insurance surrender cost index is calculated by applying the following steps:

1. Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.
2. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at 5 percent interest compounded annually to the end of the period selected and add this sum to the amount determined in subparagraph "1."
3. Divide the result of subparagraph "2" (subparagraph "1" for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subparagraph "2" (subparagraph "1" for guaranteed-cost policies) over the respective periods stipulated in subparagraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
4. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5 percent interest compounded annually to the end of the period stipulated in subparagraph "1" and dividing the result by the respective factors stated in subparagraph "3" (this amount is the annual premium payable for a level premium plan).
5. Subtract the result of subparagraph "3" from subparagraph "4."
6. Divide the result of subparagraph "5" by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

"Policy summary," for the purposes of these rules, shall mean a written statement describing the elements of the policy including but not limited to:

1. A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION.

2. The name and address of the insurance producer or, if no producer is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary.

3. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

4. The generic name of the basic policy and each rider.

5. The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier:

(a) The annual premium for the basic policy.

(b) The annual premium for each optional rider.

(c) Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide and other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately.

(d) Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

(e) Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)

(f) Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above.

6. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the policy summary includes the maximum annual percentage rate.

7. Life insurance cost indexes for 10 and 20 years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits nor for basic policies or optional riders covering more than one life.

8. The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance cost indexes are displayed.

9. A policy summary which includes dividends shall also include a statement that dividends are based on the company's illustrated scale and are not guaranteed and a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide.

10. A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended use of these indexes is provided in the life insurance buyer's guide.

11. The date on which the policy summary is prepared.

The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as not to minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in paragraph "5" of this definition shall be listed in total, not a per-thousand nor a per-unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

Appendix II
HIV ANTIBODY TEST
INFORMATION FORM FOR INSURANCE APPLICANT

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and persons who have had sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next ten years.

The HIV antibody test:

Before consenting to testing, please read the following important information:

1. Purpose. This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

2. Positive test results. If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

3. Accuracy. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100 percent accurate. Possible errors include:

a. False positives: This test gives a positive result, even though you are not infected. This happens rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.

4. Side effects. A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies for which you may apply in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results become known to others. A negative result may create a false sense of security.

5. Disclosure of results. A positive test result will be reported to you in one of the following ways. You may choose to have information about a positive test result communicated to you through your physician or through the alternative testing site. If you do not designate a physician or an alternative testing site to receive the information, the information about a positive test result will be reported to the Iowa Department of Public Health, and the Iowa Department of Public Health will contact you.

6. Confidentiality. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

7. Prevention. Persons who have a history of high-risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

8. Information. Further information about HIV testing and AIDS can be obtained by calling the national AIDS hotline at 1-800-342-2437.

INFORMED CONSENT

I hereby authorize the company and its designated medical facilities to draw samples of my blood or other bodily fluid for the purpose of laboratory testing to provide applicable medical information concerning my insurability. These tests may include but are not limited to tests for: cholesterol and related blood lipids; diabetes; liver or kidney disorders; infection by the Acquired Immune Deficiency Syndrome (HIV) virus (if permitted by law); immune disorders; or the presence of medications, drugs, nicotine or other metabolites. The tests will be done by a medically accepted procedure which is extremely reliable.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA blood or other bodily fluid test will be done.

a. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

b. If the initial ELISA blood or other bodily fluid test is negative, a negative finding will be reported to the company.

2. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

a. If the second ELISA blood or other bodily fluid test is also positive, a Western Blot blood or other bodily fluid test will be performed to confirm the positive results of the two ELISA blood or other bodily fluid tests.

b. If the second ELISA blood or other bodily fluid test is negative, a third ELISA blood or other bodily fluid test will be performed. If the third ELISA blood or other bodily fluid test is positive, a Western Blot blood or other bodily fluid test will be performed to confirm the previous positive results. If the third blood or other bodily fluid test is negative, a negative result will be reported to the company.

3. Only if at least two ELISA blood or other bodily fluid tests and a Western Blot blood or other bodily fluid test are all positive will the result be reported as a positive. All other results will be reported as negative to the company.

Without a court order or written authorization from me, these results will be made known only to the company and its reinsurers (if involved in the underwriting process). The company will provide results of all tests to a physician of my choice. Positive test results to the HIV Antibody Screen will be disclosed only to my physician or an alternative testing site as I direct below. If I do not designate a physician or alternative testing site to receive the results, the company will provide results of a positive HIV test to the Iowa Department of Public Health. In addition, the company may make a brief report to MIB, Inc., in a manner described in the Pre-notice which I received as a part of the application process. The only information the company will report to MIB, Inc. is that positive results were obtained from a blood or other bodily fluid test. The company will not report what tests were performed or that the positive result was for HIV antibodies.

These organizations will be the only ones maintaining this information in any type of file except as required by law. Positive HIV Antibody Screen results are to be reported to: (elect one) □ the Alternative Testing Site or □ my physician; _____

(name and address of attending physician)

This authorization will be valid for 90 days from the date below.

Dated At: _____Day _____ Month _____, 20 _____

Witness _____ Proposed Insured: _____

Producer (Signature) (Signature)

This rule is intended to implement Iowa Code section 505.16.

Appendix III
COMPLAINT RECORD

Column A	Column B		Column C	Column D	Column E	Column F	Column G	Column H
Company Identification Number	Function Code	Reason Code	Line Type	Company Disposition after Complaint Received	Date Received	Date Closed	Insurance Division Complaint	State of Origin
(Producer's Number)								

Explanation

A. Company Identification Number. As noted, this refers to the identification number of the complaint and shall also include the license number, name, or other means of identifying any licensee of the Insurance Division, such as a producer that may have been involved in the complaint.

B. Function Code. Complaints are to be classified by function(s) of the company involved. Separate classifications are to be maintained for underwriting, marketing and sales, claims, policyholder service and miscellaneous.
Reason Code. Complaints are also to be classified by the nature of the complaint. The following is the classification required for each function specified above.

1) Underwriting
   a) Premium and rating
   b) Refusal to insure
   c) Cancellation/renewal
   d) Delays
   e) Unfair discrimination
   f) Endorsement/rider
   g) Group conversion
   h) Medicare supplement violation
   i) Miscellaneous (not covered by above)
2) Marketing and Sales
   a) General advertising
   b) Misrepresentation
   c) Producer handling
   d) Replacement
   e) Delays
   f) Miscellaneous (not covered by above)
3) Claims
   a) Post claim underwriting
   b) Delays
   c) Unsatisfactory settlement/offer
   d) Coordination of benefits
   e) Cost containment
   f) Denial of claim
   g) Miscellaneous (not covered by above)
4) Policyholder service
   a) Premium notice/billing
   b) Cash value
   c) Delays/no response
   d) Premium refund
   e) Coverage question
   f) Miscellaneous (not covered by above)
5) Miscellaneous

C. Line Type. Complaints are to be classified according to the line of insurance involved as follows:
1) Automobile
2) Fire
3) Homeowners-Farmowners
4) Crop
5) Life and Annuity
6) Accident and Health
7) Miscellaneous (not covered by above)

D. Company Disposition After Receipt. The complaint record shall note the disposition of the complaint.
The following examples illustrate the type of information called for, but are not intended to be required language nor to exhaust the possibilities:
1. Policy issued/restored.
2. Refund.
3. Claim settled.
4. Delay resolved.
5. Question of fact.
6. Contract provision/legal issue.
7. No jurisdiction.

E. Date Received. This refers to the date the complaint was received.

F. Date Closed. This refers to the date on which the complaint was disposed of whether by one action or a series of actions as may be present in connection with some complaints.

G. Insurance Department Complaint. Complaints are to be classified so as to indicate if the com plaint was from an insurance department.

H. State of Origin. The complaint record should note the state from which the complaint originated. Ordinarily this will be the state of residence of the complainant.

Appendix IV
DISCLOSURE FORM FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

Important Information About Your Policy

The premiums you'll pay for your policy may be more than the amount of your coverage (the face amount). You can find both the face amount and the annual premium in your policy. Look for the page labeled [use the label the company uses for that information, such as "Statement of Policy Cost and Benefit Information"].

- Usually, you can figure out how many years it will take until the premiums paid will be greater than the face amount. For an estimate, divide the face amount by the annual premium. Several factors may affect how many years this might take for *your* policy. These include not paying premiums when due, taking out a policy loan, surrendering your policy for cash, policy riders, payment of dividends, if applicable, and changes in the face amount.
- Many factors will affect how much your life insurance costs. Some are your age and health, the face amount of the policy, and the cost of a policy rider. You may be able to pay less for your insurance if you answer health questions. You may also pay less if you pay your premiums less often.
- Ask your insurance agent or your insurance company if you have any questions about your premiums, your coverage, or anything else about your policy.

If You Change Your Mind . . .

- You can get a full refund of premiums you've paid if you return your policy and cancel your coverage. You *must* do this within the number of days stated on your policy's front page. To return the policy for a full refund, send it back to the agent or the company.
- If you stop paying premiums or cancel your policy *after* the time that a full refund is available, you have specific rights. Ask your insurance agent or your insurance company about your rights.

Contact Information

If you have questions about your insurance policy, ask your agent or your company. If your agent isn't available, contact your insurance company at [provide telephone number (including toll-free number if available), address and Web site (if available)].

APPENDIX V

Annuity Illustration Example

[The following illustration is an example only and does not reflect specific characteristics of any actual product for sale by any company]

ABC Life Insurance Company

Company Product Name

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

(Contact us at Policyownerservice@ABCLife.com or 555-555-5555.)

Sex: Male	Initial Premium Payment: $100,000.00
Age at Issue: 54	Planned Annual Premium Payments: None
Annuitant: John Doe	Tax Status: Nonqualified
Oldest Age at Which Annuity Payments Can Begin: 95	Withdrawals: None Illustrated

Initial Interest Guarantee Period	5 Years
Initial Guaranteed Interest Crediting Rates	
First Year (reflects first year only interest bonus credit of 0.75%):	4.15%
Remainder of Initial Interest Guarantee Period:	3.40%
Market Value Adjustment Period:	5 Years
Minimum Guaranteed Interest Rate After Initial Interest Guarantee Period*:	3%

*After the Initial Interest Guarantee Period, a new interest rate will be declared annually. This rate cannot be lower than the Minimum Guaranteed Interest Rate.

Annuity Income Options and Illustrated Monthly Income Values

This annuity is designed to pay an income that is guaranteed to last as long as the Annuitant lives. When annuity income payments are to begin, the income payment amounts will be determined by applying an annuity income rate to the annuity Account Value.

Annuity income options include the following:

- Periodic payments for Annuitant's life
- Periodic payments for Annuitant's life with payments guaranteed for a certain number of years
- Periodic payments for Annuitant's life with payments continuing for the life of a survivor annuitant

Illustrated Annuity Income Option: Monthly payments for Annuitant's life with payments guaranteed for 10-year period.

Assumed Age When Payments Start: 70

	Account Value	Monthly Annuity Income Rate/$1,000 of Account Value*	Monthly Annuity Income
Based on Rates Guaranteed in the Contract	$164,798	$5.00	$823.99
Based on Rates Currently Offered by the Company	$171,976	$6.50	$1,117.84

*If, at the time of annuitization, the annuity income rates currently offered by the company are higher than the annuity income rates guaranteed in the contract, the current rates will apply.

ABC Life Insurance Company
Company Product Name
Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)
An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy
(Contact us at Policyownerservice@ABCLife.com or 555-555-5555.)

		Values Based on Guaranteed Rates				Values Based on Assumption That Initial Guaranteed Rates Continue		
Contract Year/Age	Premium Payment	Interest Crediting Rate	Account Value	Cash Surrender Value Before MVA	Minimum Cash Surrender Value After MVA	Interest Crediting Rate	Account Value	Cash Surrender Value Before and After MVA
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1 / 55	$ 100,000	4.15%	$ 104,150	$ 95,818	$ 92,000	4.15%	$ 104,150	$ 95,818
2 / 56	0	3.40%	107,691	100,153	93,000	3.40%	107,691	100,513
3 / 57	0	3.40%	111,353	104,671	95,614	3.40%	111,353	104,671
4 / 58	0	3.40%	115,139	109,382	98,482	3.40%	115,139	109,382
5 / 59	0	3.40%	119,053	114,291	114,291	3.40%	119,053	114,291
6 / 60	0	3.00%	122,625	118,946	118,946	3.40%	123,101	119,408
7 / 61	0	3.00%	126,304	123,778	123,778	3.40%	127,287	124,741
8 / 62	0	3.00%	130,093	130,093	130,093	3.40%	131,614	131,614
9 / 63	0	3.00%	133,996	133,996	133,996	3.40%	136,089	136,089
10 / 64	0	3.00%	138,015	138,015	138,015	3.40%	140,716	140,716
11 / 65	0	3.00%	142,156	142,156	142,156	3.40%	145,501	145,501
16 / 70	0	3.00%	164,798	164,798	164,798	3.40%	171,976	171,976
21 / 75	0	3.00%	191,046	191,046	191,046	3.40%	203,268	203,268
26 / 80	0	3.00%	221,474	221,474	221,474	3.40%	240,255	240,255
31 / 85	0	3.00%	256,749	256,749	256,749	3.40%	283,972	283,972
36 / 90	0	3.00%	297,643	297,643	297,643	3.40%	335,643	335,643
41 / 95	0	3.00%	345,050	345,050	345,050	3.40%	396,717	396,717

For column descriptions, turn to page 3

Column Descriptions

(1) **Ages** shown are measured from the Annuitant's age at issue.

(2) **Premium Payments** are assumed to be made at the beginning of the Contract Year shown.

Values Based on Guaranteed Rates

(3) **Interest Crediting Rates** shown are annual rates; however, interest is credited daily. During the Initial Interest Guarantee Period, values developed from the Initial Premium Payment are illustrated using the Initial Guaranteed Interest Rate(s) declared by the insurance company, which include an additional first year only interest bonus credit of 0.75%. The interest rates will be guaranteed for the Initial Interest Guarantee Period, subject to an MVA. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually, but can never be less than the Minimum Guaranteed Interest Rate shown.

(4) **Account Value** is the amount you have at the end of each year if you leave your money in the contract until you start receiving annuity payments. It is also the amount available upon the Annuitant's death if it occurs before annuity payments begin. The death benefit is not affected by surrender charges or the MVA.

(5) **Cash Surrender Value Before MVA** is the amount available at the end of each year if you surrender the contract (after deduction of any Surrender Charge) but before the application of any MVA. Surrender charges are applied to the Account Value according to the schedule below until the surrender charge period ends, which may be after the Initial Interest Guarantee Period has ended.

Years Measured from Premium Payment:	1	2	3	4	5	6	7	8+
Surrender Charges:	8%	7%	6%	5%	4%	3%	2%	0%

(6) **Minimum Cash Surrender Value After MVA** is the minimum amount available at the end of each year if you surrender your contract before the end of five years, no matter what the MVA is. The minimum is set by law. The amount you receive may be higher or lower than the cash surrender value due to the application of the MVA, but never lower than this minimum. Otherwise the MVA works as follows: If the interest rate available on new contracts offered by the company is LOWER than your Initial Guaranteed Interest Rate, the MVA will INCREASE the amount you receive. If the interest rate available on new contracts offered by the company is HIGHER than your Initial Guaranteed Interest Rate, the MVA will DECREASE the amount you receive. Page 4 of this illustration provides additional information concerning the MVA.

Values Based on Assumption That Initial Guaranteed Rates Continue

(7) **Interest Crediting Rates** are the same as in Column (3) for the Initial Interest Guarantee Period. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually. For the purposes of calculating the values in this column, it is assumed that the Initial Guaranteed Interest Rate (without the bonus) will continue as the new renewal interest rate in all years. The actual renewal interest rates are not subject to an MVA and will very likely NOT be the same as the illustrated renewal interest rates.

(8) **Account Value** is calculated the same way as Column (4).

(9) **Cash Surrender Value Before and After MVA** is the Cash Surrender Value at the end of each year assuming that Initial Guaranteed Interest Rates continue, and that the continuing rates are the rates offered by the company on new contracts. In this case, the MVA would be zero, and Cash Surrender Values before and after the MVA would be the same.

Important Note: This illustration assumes you will take **no** withdrawals from your annuity before you begin to receive periodic income payments. **Withdrawals will reduce both the annuity Account Value and the Cash Surrender Value.** You may make partial withdrawals of up to 10% of your account value each contract year without paying surrender charges. Excess withdrawals (above 10%) and full withdrawals will be subject to surrender charges.

This illustration assumes the annuity's current interest crediting rates will not change. It is likely that they will change and actual values may be higher or lower than those in the illustration.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. For more information, read the annuity disclosure and annuity buyer's guide.

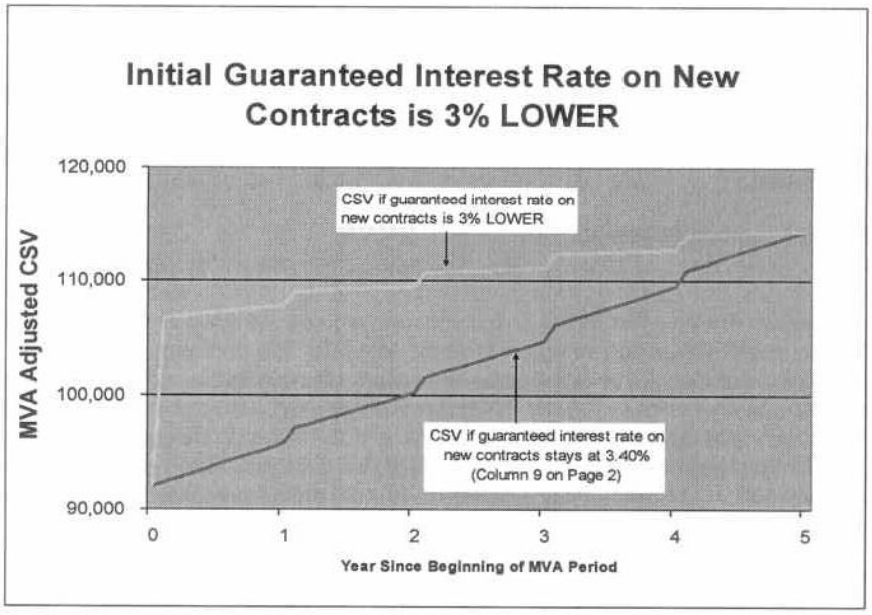
MVA-Adjusted Cash Surrender Values (CSVs) Under Sample Scenarios

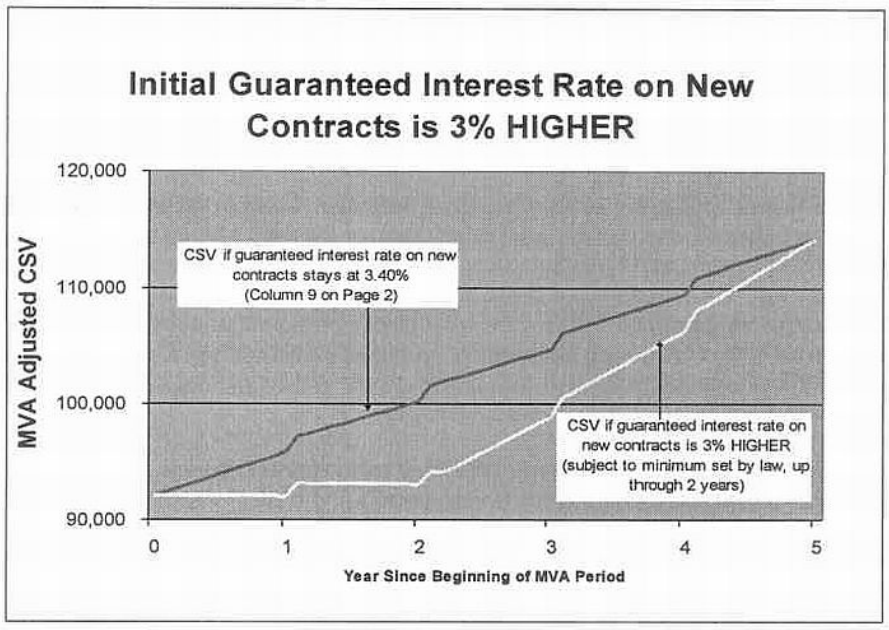
The graphs below* show MVA-adjusted Cash Surrender Values (CSVs) during the first five years of the contract, as illustrated on page 2 ($100,000 single premium, a 5-year MVA Period) under two sample scenarios, as described below.

Graph #1 shows if the interest rate on new contracts is 3% LOWER than your Initial Guaranteed Interest Rate, the MVA will increase the amount you receive (green line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

Graph #2 shows if the interest rate on new contracts is 3% HIGHER than your Initial Guaranteed Interest Rate, the MVA will decrease the amount you receive, but not below the minimum set by law (Column (6) on Page 2), which in this scenario limits the decrease for the first 2 years (yellow line). The pink line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on Page 2).

These graphs and the sample guaranteed interest rates on new contracts used are for demonstration purposes only and are not intended to be a projection of how guaranteed interest rates on new contracts are likely to behave.





*Color not reproducible in the Iowa Administrative Code.

Page 4 of 4

[**ARC 0035C**, IAB 3/7/12, effective 4/11/12]

These rules are intended to implement Iowa Code chapters 507B and 522B.

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◊ Two or more ARCs

1 The Administrative Rules Review Committee at their February 13, 1979, meeting delayed the effective date of rules 15.90 to 15.93 seventy days.

2 Effective date (12/31/81) of rules 15.9 and 15.31 delayed 70 days by the Administrative Rules Review Committee.

3 At its meeting held August 13, 2003, the Administrative Rules Review Committee voted to delay the effective date of 15.43(10) until adjournment of the 2004 Session of the General Assembly.

UTILITIES DIVISION[199]

Former Commerce Commission[250] renamed Utilities Division[199]
under the "umbrella" of Commerce Department[181] by 1986 Iowa Acts, Senate File 2175, section 740.

CHAPTER 5
PROCEDURE FOR DETERMINING THE COMPETITIVENESS OF A COMMUNICATIONS SERVICE OR FACILITY

CHAPTER 6
COMPLAINT PROCEDURES

CHAPTER 7
PRACTICE AND PROCEDURE

UTILITIES AND
TRANSPORTATION DIVISIONS

CHAPTER 15
COGENERATION AND SMALL POWER PRODUCTION

CHAPTER 16
ACCOUNTING

CHAPTER 17
ASSESSMENTS

CHAPTER 18
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CHAPTER 1
GENERAL

[Prior to 6/15/88, see Professional Teaching Practices Commission[640] Ch 1]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287] Ch 1]

282—1.1(272) Definition. The board of educational examiners shall hereinafter be referred to as the "board."

This rule is intended to implement Iowa Code chapter 272.

282—1.2(272,17A) Organization and method of operation.

1.2(1) *History.* The board was created by Iowa Code chapter 272.

1.2(2) *Composition.* The composition of the board is defined in Iowa Code section 272.3.

1.2(3) *Executive director.* The executive director is appointed by the board and acts as executive head of the agency. The executive director is responsible for the administration of the board.

1.2(4) *Major statutory function.* The board is created to exercise the exclusive authority to license practitioners and professional development programs, except for programs offered by practitioner preparation institutions or area education agencies and approved by the state board of education. Licensing authority includes the authority to establish criteria for the licenses, creation of application and renewal forms, development of a code of professional rights and responsibilities, practices, and ethics.

1.2(5) *Conduct of business.* The ordinary business of the board is conducted at its regular meetings generally held at the Grimes State Office Building, Des Moines, Iowa.

a. The board shall biennially, at its regularly scheduled meeting in June, elect a chair from its membership to begin serving upon election.

b. The board shall approve annual meeting dates at least by June 30.

c. The board may schedule special meetings called by the chair or upon request to the chair by six members of the board or upon request of the executive director. Special meetings may be held by electronic means in accordance with Iowa Code section 21.8.

d. The board will post the date, time, and location of board meetings.

e. Persons who wish to submit materials for the agenda and appear before the board, or whose presence has been requested by the board, will be provided the opportunity to address the board.

f. In order to be placed on the agenda, materials must be received at least two weeks prior to a scheduled board meeting. Materials from emergency or unusual circumstances may be added to the agenda with the chair's approval.

g. The board will govern its meetings in accordance with Iowa Code chapter 21 and its proceedings by Robert's Rules of Order, Revised.

h. All board meetings shall be open, and the public shall be permitted to attend the meetings, unless the board votes to hold a closed session in accordance with Iowa Code section 21.5.

i. Persons in attendance at board meetings may be granted an opportunity to speak on an issue before the board at the discretion of the chair. The length and frequency of public comment will be at the discretion of the chair.

j. Information, submissions or requests. General inquiries regarding the board, requests for forms and other documents and all other requests and submissions may be addressed to the Executive Director, Board of Educational Examiners, Grimes State Office Building, Des Moines, Iowa 50319-0147.

This rule is intended to implement Iowa Code chapter 272.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

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CHAPTER 3
DECLARATORY ORDERS

[Prior to 5/16/90, see Professional Teaching Practices Commission[287] Ch 1]

The board of educational examiners hereby adopts the declaratory orders segment of the Uniform Rules on Agency Procedure printed in the first volume of the Iowa Administrative Code, with the following amendments:

282—3.1(17A) Petition for declaratory order. Throughout the rule, in lieu of the words "(designate agency)", insert "the Board of Educational Examiners, Grimes State Office Building". In lieu of the words "(AGENCY NAME)", in the heading on the petition insert "BEFORE THE BOARD OF EDUCATIONAL EXAMINERS".

282—3.2(17A) Notice of petition. In lieu of the words "___ days (15 or less)", insert "15 days".

282—3.3(17A) Intervention.

3.3(1) In lieu of the words "___ days", insert "15 days".

282—3.5(17A) Inquiries. In lieu of the words "(designate official by full title and address)", insert "Executive Director, Board of Educational Examiners, Grimes State Office Building, Des Moines, Iowa 50319-0147".

These rules are intended to implement Iowa Code section 17A.9.

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CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

[Prior to 6/15/88, see Professional Teaching Practices Commission[640] Ch 7]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287] Ch 7]

The board of educational examiners hereby adopts, with the following exceptions and amendments, rules of the Governor's Task Force on Uniform Rules of Agency Procedure relating to public records and fair information practices which are printed in the first volume of the Iowa Administrative Code.

282—5.1(22,272) Definitions. As used in this chapter:

"Agency." In lieu of the words "(official or body issuing these rules)", insert "Board of Educational Examiners".

282—5.3(22,272) Request for access to records.

5.3(1) *Location of record.* In lieu of the words "(insert agency head)", insert "office where the record is kept". In lieu of the words "(insert agency name and address)", insert "Board of Educational Examiners, Grimes State Office Building, Des Moines, Iowa 50319-0147".

5.3(2) *Office hours.* In lieu of the words "(insert customary office hours and, if agency does not have customary office hours of at least thirty hours per week, insert hours specified in Iowa Code section 22.4)", insert "any time from 8 a.m. to 4:30 p.m. Monday through Friday, excluding legal holidays".

5.3(7) *Fees.*

c. *Supervisory fee.* In lieu of the words "(specify time period)", insert "one-half hour". In lieu of the words "(An agency wishing to deal with search fees authorized by law should do so here.)", insert "The agency will give advance notice to the requester if it will be necessary to use an employee with a higher hourly wage in order to find or supervise the particular records in question, and shall indicate the amount of that higher hourly wage to the requester".

282—5.6(22,272) Procedure by which additions, dissents, or objections may be entered into certain records. In lieu of the words "(designate office)", insert "the office of the executive director of the board".

282—5.9(22,272) Disclosures without the consent of the subject.

5.9(1) Open records are routinely disclosed without the consent of the subject.

5.9(2) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject. Following are instances where disclosure, if lawful, will generally occur without notice to the subject:

a. For a routine use as defined in rule 282—5.10(22,272) or in the notice for a particular record system.

b. To a recipient who has provided the agency with advance written assurance that the record will be used solely as a statistical research or reporting record, provided that the record is transferred in a form that does not identify the subject.

c. To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if an authorized representative of the government agency or instrumentality has submitted a written request to the agency specifying the record desired and the law enforcement activity for which the record is sought.

d. To an individual pursuant to a showing of compelling circumstances affecting the health or safety of an individual if a notice of the disclosure is transmitted to the last-known address of the subject.

e. To the legislative services agency under Iowa Code section 2A.3.

f. Disclosures in the course of employee disciplinary proceedings.

g. In response to a court order or subpoena.

282—5.10(22,272) Routine use.

5.10(1) "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.

5.10(2) To the extent allowed by law, the following are considered routine uses of all agency records:

a. Disclosure to officers, employees, and agents of the agency who have a need for the record in the performance of their duties. The custodian of the record may, upon request of any officer or employee, or on the initiative of the custodian, 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 criminal 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 agency.

d. Transfers of information within the agency, 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 agency is operating a program lawfully.

f. Any disclosure specifically authorized by the statute under which the record is collected or maintained.

282—5.11(272) Consensual disclosure of confidential records.

5.11(1) *Consent to disclosure by a subject.* To the extent permitted by law, the subject may consent in writing to agency disclosure of confidential records as provided in rule 282—5.7(272).

5.11(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 agency may, to the extent permitted by law, be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

282—5.12(272) Release to subject.

5.12(1) The subject of a confidential record may file a written request to review the subject's confidential records as provided in rule 282—5.6(272). However, the agency need not release the following records to the subject:

a. The identity of a person providing information to the agency when the information is authorized as confidential pursuant to Iowa Code subsection 22.7(18) or other provisions of law.

b. The work product of an attorney or otherwise privileged information.

c. Peace officers' investigative report, except as required by Iowa Code subsection 22.7(5).

d. Those otherwise authorized by law.

5.12(2) Where a record has multiple subjects with interests in the confidentiality of the record, the agency may take reasonable steps to protect confidential information relating to another subject.

282—5.13(272) Availability of records.

5.13(1) *Open records.* Agency records are open for public inspection and copying unless otherwise provided by rule or law.

5.13(2) *Confidential records.* The following records may be withheld from public inspection. Records are listed by category, according to the legal basis for withholding them from public inspection.

a. Sealed bids received prior to the time set for public opening of bids under Iowa Code section 72.3.

b. Tax records made available to the agency under Iowa Code sections 422.20 and 422.72.

c. Records which are exempt from disclosure under Iowa Code section 22.7.

d. Minutes of closed meetings of the board of educational examiners under Iowa Code subsection 21.5(4).

e. Identifying details in final orders, decisions and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy or trade secrets under Iowa Code paragraph 17A.3(1)*"d."*

f. Portions of the agency's staff manuals, instructions or other statements issued which set forth criteria or guidelines to be used by agency 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 disclosure of these statements would:

(1) Enable law violators to avoid detection,

(2) Facilitate disregard of requirements imposed by law, or

(3) Give a clearly improper advantage to persons who are in an adverse position to the agency under Iowa Code sections 17A.2 and 17A.3.

g. Records which constitute attorney work product, attorney-client communications, or which are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4), 622.10 and 622.11, Iowa R. Civ. 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 Code of Professional Responsibility, and case law.

h. Any other records considered confidential under the law such as agency investigative reports collected to determine if probable cause exists to institute a contested case proceeding pursuant to Iowa Code chapter 272.

5.13(3) *Authority to release confidential records.* The agency may have discretion to disclose some confidential records which are exempt from disclosure under Iowa Code section 22.7 or other law. Any person may request permission to inspect records withheld from inspection under a statute which authorizes limited or discretionary disclosure as provided in rule 282—5.4(272). If the agency initially determines that it will release such records, the agency may, where appropriate, notify interested parties and withhold the records from inspection as provided in subrule 5.4(3).

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—5.14(272) Personally identifiable information. This rule describes the nature and extent of the personally identifiable information which is collected, maintained, and retrieved by the agency by personal identifier in record systems as defined in rule 282—5.1(272). For each record system, this rule describes the legal authority for the collection of information, the means of storage of information and whether a data processing system matches, collates or permits the comparison of personally identifiable information in one record system with that in another record system. The record systems maintained by the agency are:

5.14(1) *Cases dismissed.* These records contain data supplied by persons or parties filing complaints and responses with the agency, and contain personally identifiable information such as student name(s), teacher name, administrator name, addresses, disciplinary records, and investigatory reports. This information is collected pursuant to Iowa Code chapter 272 and this chapter, and is stored on paper; most of the data are on an automated data processing system.

5.14(2) *Cases decided.* These records contain data supplied by persons or parties filing complaints and responses with the agency and contain personally identifiable information such as student name(s), teacher name, administrator name, addresses, disciplinary records, and investigatory reports. This information is collected pursuant to Iowa Code chapter 272 and this chapter and is stored on paper; most of the data are on an automated data processing system.

5.14(3) *Litigation files.* These files or records contain information regarding litigation or anticipated litigation, which includes judicial and administrative proceedings. The records include briefs, depositions, docket sheets, documents, correspondence, attorney's notes, memoranda, research materials, witness information, investigation materials, information compiled under the direction of the attorney, and case management records. The files contain materials which are confidential as attorney work product and attorney-client communications. Some materials are confidential under other applicable provisions of law or because of a court order. Persons wishing copies of pleadings and

other documents filed in litigation should obtain these from the clerk of the appropriate court which maintains the official copy.

282—5.15(272) Other groups of records. This rule describes groups of records maintained by the agency other than record systems as defined in rule 282—5.2(272). These records are routinely available to the public; however, the agency's files of these records may contain confidential information or information about individuals that is not confidential as discussed in rule 282—5.13(272). All records are stored both on paper and in automated data processing systems unless otherwise noted.

5.15(1) *Rule making.* Rule-making records may contain information about individuals making written or oral comments on proposed rules or proposing rules or rule amendments. This information is collected pursuant to Iowa Code sections 17A.3, 17A.4, and 17A.7. These records are stored on paper and not in an automated data processing system.

5.15(2) *Board records.* Records contain agendas, minutes, and materials presented to the board. Records concerning closed sessions are exempt from disclosure under Iowa Code subsection 21.5(4). Board records contain information about people who participate in meetings. This information is collected under the authority of Iowa Code section 21.3. Board records are not stored in an automated data processing system.

5.15(3) *Publications.* Publications include brochures, annual reports, video tapes, and other informational materials which describe various agency programs. Agency publications may contain information about individuals, including agency staff or members of the board. This information is not stored in an automated data processing system.

5.15(4) *Statistical reports.* Periodic reports of agency decisions are available from the board. Statistical reports are stored in an automated data processing system.

5.15(5) *Address lists/directories.* The names and mailing addresses of members of boards in other states, professional organizations, public press, and members of the general public evidencing interest in particular events of the agency are maintained in order to provide mailing labels for mass distribution of literature. This information is collected under the provisions of Iowa Code chapter 272.

5.15(6) *Case decisions and declaratory rulings.* All final orders, decisions and rulings are available for public inspection in accordance with Iowa Code section 17A.3. These records may contain personally identifiable information regarding individuals who are the subjects of the appeals or rulings. This information is collected pursuant to Iowa Code chapters 17A and 272 and 282—Chapter 5 and is not stored in an automated data processing system.

5.15(7) *Board budget records.* These records contain data used by the board to develop annual budgets. These records are stored on hard copy and on automated data processing.

282—5.16(272) Applicability. This chapter does not:

1. Require the agency to index or retrieve records which contain information about individuals by that person's name or other personal identifier.
2. Make available to the general public records which would otherwise not be available under the public records law, Iowa Code chapter 22.
3. Govern the maintenance or disclosure of, notification of or access to, records in the possession of the agency which are governed by the regulations of another agency.
4. Apply to grantees, including local governments or subdivisions thereof, administering state-funded programs, unless otherwise provided by law or agreement.
5. Make available records compiled by the agency in reasonable anticipation of court litigation or formal administrative proceedings. The availability of such records to the general public or to any subject 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 to the agency.

These rules are intended to implement Iowa Code section 22.11.

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CHAPTER 10
CHILD SUPPORT NONCOMPLIANCE

282—10.1(272,252J) Issuance or renewal of a license—denial. The board shall deny the issuance or renewal of a license upon the receipt of a certificate of noncompliance from the child support recovery unit of the department of human services according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the following shall apply.

10.1(1) The notice required by Iowa Code section 252J.8 shall be served upon the applicant or licensee by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the applicant or licensee may accept service personally or through authorized counsel.

10.1(2) The effective date of the denial of the issuance or renewal of a license, as specified in the notice required by Iowa Code section 252J.8, shall be 60 days following service of the notice upon the applicant or licensee.

10.1(3) The board's administrator is authorized to prepare and serve the notice required by Iowa Code section 252J.8 upon the applicant or licensee.

10.1(4) Applicants and licensees shall keep the board informed of all court actions and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J and shall provide the board copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

10.1(5) All board fees required for application, license renewal, or license reinstatement must be paid by applicants or licensees before a license will be issued, renewed, or reinstated after the board has denied the issuance or renewal of a license pursuant to Iowa Code chapter 252J.

10.1(6) In the event an applicant or licensee files a timely district court action following service of a board notice pursuant to Iowa Code sections 252J.8 and 252J.9, the board shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the denial of the issuance or renewal of a license, the board shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

10.1(7) The board shall notify the applicant or licensee in writing through regular first-class mail, or such other means as the board determines appropriate in the circumstances, within ten days of the effective date of the denial of the issuance or renewal of a license, and shall similarly notify the applicant or licensee if the license is issued or renewed following the board's receipt of a withdrawal of the certificate of noncompliance.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—10.2(252J) Suspension or revocation of a license. The board shall suspend or revoke a license upon the receipt of a certificate of noncompliance from the child support recovery unit of the department of human services according to the procedures set forth in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the following shall apply.

10.2(1) The notice required by Iowa Code section 252J.8 shall be served upon the licensee by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the licensee may accept service personally or through authorized counsel.

10.2(2) The effective date of the suspension or revocation of a license, as specified in the notice required by Iowa Code section 252J.8, shall be 60 days following service of the notice upon the licensee.

10.2(3) The board's administrator is authorized to prepare and serve the notice required by Iowa Code section 252J.8 and is directed to notify the licensee that the license will be suspended unless the license is already suspended on other grounds. In the event that the license is on suspension, the administrator shall notify the licensee of the board's intention to continue the suspension.

10.2(4) The licensee shall keep the board informed of all court actions and all child support recovery unit action taken under or in connection with Iowa Code chapter 252J and shall provide the board copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in such actions and withdrawals of certificates of noncompliance by the child support recovery unit.

10.2(5) All board fees required for license renewal or license reinstatement must be paid by licensees before a license will be reinstated after the board has suspended or revoked a license pursuant to Iowa Code chapter 252J.

10.2(6) In the event a licensee files a district court action following service of a board notice pursuant to Iowa Code sections 252J.8 and 252J.9, the board shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the suspension or revocation, the board shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

10.2(7) The board shall notify the licensee in writing through regular first-class mail, or such other means as the board determines appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a license, and shall similarly notify the licensee if the license is reinstated following the board's receipt of a withdrawal of the certificate of noncompliance.
[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—10.3(17A,22,252J) Sharing of information. Notwithstanding any statutory confidentiality provision, the board may share information with the child support recovery unit of the department of human services through manual or automated means for the sole purpose of identifying applicants or licensees subject to enforcement under Iowa Code chapter 252J or 598.
[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

These rules are intended to implement Iowa Code chapter 252J.

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CHAPTER 11
COMPLAINTS, INVESTIGATIONS, CONTESTED CASE HEARINGS

[Prior to 6/15/88, see Professional Teaching Practices Commission[640] Ch 2]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287] Ch 2]

282—11.1(17A,272) Scope and applicability. This chapter applies to contested case proceedings conducted by the board of educational examiners.

282—11.2(17A) Definitions. Except where otherwise specifically defined by law:

"Board" means the board of educational examiners.

"Complainant" means any qualified party who files a complaint with the board.

"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 an administrative law judge from the Iowa department of inspections and appeals or the full board or a three-member panel of the board.

"Proposed decision" means the presiding officer's recommended findings of fact, conclusions of law, decision, and order in a contested case in which the full board did not preside.

"Respondent" means any individual who is charged in a complaint with violating the criteria of professional practices or the criteria of competent performance.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.3(17A,272) Jurisdictional requirements.

11.3(1) The case must relate to alleged violation of the criteria of professional practices or the criteria of competent performance.

11.3(2) The magnitude of the alleged violation must be adequate to warrant a hearing by the board.

11.3(3) There must be sufficient evidence to support the complaint.

11.3(4) The complaint must be filed by a person who has personal knowledge of an alleged violation and must include a concise statement of facts which clearly and specifically apprises the respondent of the details of the allegation(s).

11.3(5) The complaint must be filed within three years of the occurrence of the conduct upon which it is based or discovery of the conduct by the complainant unless good cause can be shown for extension of this limitation.

11.3(6) The jurisdictional requirements must be met on the face of the complaint before the board may order an investigation of the allegation(s) of the complaint.

11.3(7) As an additional factor, it should appear that a reasonable effort has been made to resolve the problem on the local level. However, the absence of such an effort shall not preclude investigation by the board.

282—11.4(17A,272) Complaint.

11.4(1) *Who may initiate.* The following entities may initiate a complaint:

a. Licensed practitioners employed by a school district or their educational entity or their recognized local or state professional organization.

b. Local boards of education.

c. Parents or guardians of students involved in the alleged complaint.

d. The executive director of the board of educational examiners if the following circumstances have been met:

(1) The executive director receives information that a practitioner:

1. Has been convicted of a felony criminal offense, or a misdemeanor criminal offense wherein the victim of the crime was 18 years of age or younger, and the executive director expressly determines within the complaint that the nature of the offense clearly and directly impacts the practitioner's fitness or ability to retain the specific license(s) or authorization(s) which the practitioner holds; or

2. Has been the subject of a founded report of child abuse placed upon the central registry maintained by the department of human services pursuant to Iowa Code section 232.71D and the executive director expressly determines within the complaint that the nature of the offense clearly and directly impacts the practitioner's fitness or ability to retain the specific license(s) or authorization(s) which the practitioner holds; or

3. Has not met a reporting requirement stipulated by Iowa Code section 272.15, Iowa Code section 279.43, 281—subrule 102.11(2), 282—Chapter 11, or 282—Chapter 25; or

4. Has falsified a license or authorization issued by the board; or

5. Has submitted false information on a license or authorization application filed with the board; or

6. Does not hold the appropriate license for the assignment for which the practitioner is currently employed; or

7. Has assigned another practitioner to perform services for which the practitioner is not properly licensed; and

(2) The executive director verifies the information or the alleged misconduct through review of official records maintained by a court, the department of human services registry of founded child abuse reports, the practitioner licensing authority of another state, the department of education, the local school district, area education agency, or authorities in charge of the nonpublic school, or the executive director is presented with the falsified license; and

(3) No other complaint has been filed.

e. The department of transportation if the licensee named in the complaint holds a behind-the-wheel instructor's certification issued by the department and the complaint relates to an incident or incidents arising during the course of driver's education instruction.

f. An employee of the department of education who, while performing official duties, becomes aware of any alleged misconduct by an individual licensed under Iowa Code section 272.2.

11.4(2) *Form and content of the complaint.*

a. The complaint shall be in writing and signed by at least one complainant who has personal knowledge of an alleged violation of the board's rules or related state law or an authorized representative if the complainant is an organization. (An official form may be used. This form may be obtained from the board upon request.)

b. The complaint shall show venue as "BEFORE THE BOARD OF EDUCATIONAL EXAMINERS" and shall be captioned "COMPLAINT."

c. The complaint shall contain the following information:

(1) The full name, address and telephone number of the complainant.

(2) The full name, address and telephone number, if known, of the respondent.

(3) A concise statement of the facts which clearly and specifically apprises the respondent of the details of the alleged violation of the criteria of professional practices or the criteria of competent performance and the relief sought by the complainant.

(4) An explanation of the basis of the complainant's personal knowledge of the facts underlying the complaint.

(5) A citation to the specific rule or law which the complainant alleges has been violated.

11.4(3) *Required copies—place and time of filing the complaint.*

a. A copy of the complaint must be filed with the board.

b. The complaint must be delivered personally or by mail to the office of the board. The current office address is the Grimes State Office Building, Third Floor, Des Moines, Iowa 50319-0147.

c. Timely filing is required in order to ensure the availability of witnesses and to avoid initiation of an investigation under conditions which may have been significantly altered during the period of delay.

The conduct upon which it is based must have occurred or been discovered by the complainant within three years of filing of the complaint unless good cause is shown for an extension of this limitation.

11.4(4) *Amendment or withdrawal of complaint.* A complaint or any specification thereof may be amended or withdrawn by the complainant at any time. The parties to a complaint may mutually agree to the resolution of the complaint at any time in the proceeding prior to issuance of a final order by the board. The resolution must be committed to a written agreement and filed with the board. The agreement is not subject to approval by the board, but shall be acknowledged by the board and may be incorporated into an order of the board.

11.4(5) *Respondent entitled to copy of the complaint.* Immediately upon the board's determination that jurisdictional requirements have been met, the respondent shall be provided a copy of the complaint or amended complaint and any supporting documents attached to the complaint at the time of filing.

11.4(6) *Voluntary surrender of license—agreement to accept lesser sanction.* A practitioner may voluntarily surrender the practitioner's license or agree to accept a lesser sanction from the board prior to or after the filing of a complaint with the board without admitting the truth of the allegations of the complaint if a complaint is on file with the board. In order to voluntarily surrender a license or submit to a sanction, the practitioner must waive the right to hearing before the board and notify the board of the intent to surrender or accept sanction. The board may issue an order permanently revoking the practitioner's license if it is surrendered, or implementing the agreed upon sanction. The board may decline to issue an agreed upon sanction if, in the board's judgment, the agreed upon sanction is not appropriate for the circumstances of the case.

11.4(7) *Investigation of license reports.*

a. Reports received by the board from another state, territory or other jurisdiction concerning licenses or certificate revocation or suspension shall be reviewed and investigated by the board in the same manner as is prescribed in these rules for the review and investigation of written complaints.

b. Failure to report a license revocation, suspension or other disciplinary action taken by licensing authority of another state, territory or jurisdiction within 30 days of the final action by such licensing authority shall constitute cause for initiation of an investigation.

11.4(8) *Timely resolution of complaints.* Complaints filed with the board must be resolved within 180 days unless good cause can be shown for an extension of this limitation. The board will provide notice to the parties to a complaint prior to taking action to extend this time limitation upon its own motion.

11.4(9) *Confidentiality.* All complaint files, investigation files, other investigation reports, and other investigation information in the possession of the board or its employees or agents, which relate to licensee discipline, are privileged and confidential, and are not subject to discovery, subpoena, or other means of legal compulsion for their release to a person other than the respondent and the board and its employees and agents involved in licensee discipline, and are not admissible in evidence in a judicial or administrative proceeding other than the proceeding involving licensee discipline. However, investigative information in the possession of the board or its employees or agents which is related to licensee discipline may be disclosed to appropriate licensing authorities within this state, the appropriate licensing authorities in another state, the District of Columbia, or a territory or country in which the licensee is licensed or has applied for a license. A final written decision and finding of fact by the board in a disciplinary proceeding is a public record.

[**ARC 8406B**, IAB 12/16/09, effective 1/20/10 (See Delay note at end of chapter); **ARC 8823B**, IAB 6/2/10, effective 5/14/10; **ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.5(272) Investigation of complaints or license reports. The chairperson of the board or the chairperson's designee may request an investigator to investigate the complaint or report received by the board from another state, territory or other jurisdiction concerning license or certificate revocation or suspension pursuant to subrule 11.4(7); providing that the jurisdictional requirements have been met on the face of the complaint. The investigation shall be limited to the allegations contained on the face of the complaint. The investigator may consult an assistant attorney general concerning the investigation or evidence produced from the investigation. Upon completion of the investigation, the investigator shall

prepare a report of the investigation for consideration by the board in determining whether probable cause exists.

282—11.6(272) Ruling on the initial inquiry. Upon review of the investigator's report, the board may take any of the following actions:

11.6(1) *Reject the case.* If a determination is made by the board to reject the case, the complaint shall be returned to the complainant along with a statement specifying the reasons for rejection. A letter of explanation concerning the decision of the board shall be sent to the respondent.

11.6(2) *Require further inquiry.* If determination is made by the board to order further inquiry, the complaint and recommendations by the investigator(s) shall be returned to the investigator(s) along with a statement specifying the information deemed necessary.

11.6(3) *Accept the case.* If a determination is made by the board that probable cause exists to conclude that the criteria of professional practices or the criteria of competent performance have been violated, notice shall be issued, pursuant to rule 282—11.7(17A,272), and a formal hearing shall be conducted in accordance with rules 282—11.7(17A,272) to 282—11.21(17A,272), unless a voluntary waiver of hearing has been filed by the respondent pursuant to the provisions of subrule 11.4(6).

11.6(4) *Release of investigative report.* If the board finds probable cause of a violation, the investigative report will be available to the respondent upon request. Information contained within the report is confidential and may be used only in connection with the disciplinary proceedings before the board.

282—11.7(17A,272) Notice of hearing.

11.7(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.

11.7(2) *Contents.* The notice of hearing shall contain the following information:

a. A statement of the time, date, 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 matter asserted;

e. Identification of all parties including the name, address and telephone numbers of counsel representing each of the parties where known;

f. Reference to the procedural rules governing conduct of the contested case proceeding;

g. Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer; and

h. Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11 and rule 282—11.8(17A,272), that the presiding officer be an administrative law judge.

282—11.8(17A,272) Presiding officer.

11.8(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 after service of a notice of hearing which identifies or describes the presiding officer as the board.

11.8(2) The board may deny the request only upon a finding that one or more of the following apply:

a. Neither the board nor any officer of the board 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. An administrative law judge with the qualifications identified in subrule 11.8(4) 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.

11.8(3) The board shall issue a written ruling specifying the grounds for its decision within 20 days after a request for an administrative law judge is filed. If the ruling is contingent upon the availability of an administrative law judge with the qualifications identified in subrule 11.8(4), the parties shall be notified at least 10 days prior to hearing if a qualified administrative law judge will not be available.

11.8(4) An administrative law judge assigned to act as presiding officer in a contested case shall have the following technical expertness unless waived by the board:

a. A J.D. degree.

b. Additional criteria may be added by the board.

11.8(5) 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 board. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

11.8(6) Unless otherwise provided by law, the board, 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.

282—11.9(17A,272) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the board in its discretion may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

282—11.10(17A,272) 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.

282—11.11(17A,272) Disqualification.

11.11(1) A presiding officer or board member 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.

11.11(2) The term "personally investigated" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term "personally investigated" does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17 and subrules 11.11(3) and 11.24(9).

11.11(3) In a situation where a presiding officer or board member 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.

11.11(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 11.11(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 the presiding officer determines that disqualification is appropriate, the presiding officer or board member 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 282—11.26(17A,272) and seek a stay under rule 282—11.30(17A,272).
[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.12(17A,272) Consolidation—severance.

11.12(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.

11.12(2) *Severance.* The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

282—11.13(17A,272) Pleadings.

11.13(1) Pleadings may be required by rule, by the notice of hearing, or by order of the presiding officer.

11.13(2) Answer. An answer shall be filed within 20 days of service of the notice of hearing 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 notice of hearing 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 notice of hearing 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.

11.13(3) Amendment. Notices of hearing and answers may be amended with the consent of the parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

282—11.14(17A,272) Service and filing of pleadings and other papers.

11.14(1) *Service—when required.* Except where otherwise provided by law, every document filed in a contested case proceeding shall be served upon each of the parties of record to the proceeding, 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.

11.14(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.

11.14(3) *Filing—when required.* After the notice of hearing, all documents in a contested case proceeding shall be filed with the Board of Educational Examiners, Grimes State Office Building, Des Moines, Iowa 50319-0147. All documents that are required to be served upon a party shall be filed simultaneously with the board.

11.14(4) *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the board, 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.

11.14(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 (agency office and address) 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)

282—11.15(17A,272) Discovery.

11.15(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.

11.15(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 11.15(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

11.15(3) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible under rule 282—11.22(17A,272). In discovery matters, the parties shall honor the rules of privilege imposed by law.

282—11.16(17A,272) Subpoenas.

11.16(1) *Subpoenas.* In connection with the investigation set forth in rule 282—11.5(272), the board is authorized by law to subpoena books, papers, records and any other evidence to help it determine whether it should institute a contested case proceeding (hearing). After service of the hearing notification contemplated by rule 282—11.7(17A,272), the following procedures are available to the parties in order to obtain relevant and material evidence:

a. Board subpoenas for books, papers, records, and other evidence will be issued to a party upon request. Such a request must be in writing. Application should be made to the board office specifying the evidence sought. Subpoenas for witnesses may also be obtained.

b. Evidence obtained by subpoena shall be admissible at the hearing if it is otherwise admissible under rule 282—11.22(17A,272). In subpoena matters the parties shall honor the rules of privilege imposed by law.

c. The evidence outlined in Iowa Code section 17A.13(2) where applicable and relevant shall be made available to a party upon request.

d. 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.

11.16(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.

282—11.17(17A,272) Motions.

11.17(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.

11.17(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 agency or the presiding officer.

11.17(3) The presiding officer may schedule oral arguments on any motion.

11.17(4) Motions pertaining to the hearing, including 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 agency or an order of the presiding officer.

282—11.18(17A,272) Prehearing conference.

11.18(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 conducted not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the presiding officer to all parties. For good cause the presiding officer may permit variances from this rule.

11.18(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.

11.18(3) In addition to the requirements of subrule 11.18(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.

11.18(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.

282—11.19(17A,272) Continuances. A party has no automatic right to a continuance or delay of the board's hearing procedure or schedule. However, a party may request a continuance of the presiding officer no later than seven days prior to the date set for hearing. The presiding officer shall have the power to grant continuances. Within seven days of the date set for hearing, no continuances shall be granted

except for extraordinary, extenuating or emergency circumstances. In these situations, the presiding officer shall grant continuances after consultation, if needed, with the chairperson of the board, the executive director, or the attorney representing the board. A board member shall not be contacted in person, by mail or telephone by a party seeking a continuance.

282—11.20(17A,272) Intervention.

11.20(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.

11.20(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.

11.20(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.

11.20(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.

282—11.21(17A,272) Hearing procedures.

11.21(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. If the presiding officer is the board or a panel thereof, an administrative law judge from the Iowa department of inspections and appeals may be designated to assist the board in conducting proceedings under this chapter. An administrative law judge so designated may rule upon motions and other procedural matters and assist the board in conducting the hearing.

11.21(2) All objections shall be timely made and stated on the record.

11.21(3) Legal representation.

a. The respondent has a right to participate in all hearings or prehearing conferences and may be represented by an attorney or another person authorized by law.

b. The office of the attorney general or an attorney designated by the executive director shall be responsible for prosecuting complaint allegations in all contested case proceedings before the board, except those cases in which the sole allegation involves the failure of a practitioner to fulfill contractual obligations. The assistant attorney general or other designated attorney assigned to prosecute a contested case before the board shall not represent the board or the complainant in that case, but shall represent the public interest.

c. In a case in which the sole allegation involves the failure of a practitioner to fulfill contractual obligations, the person who files the complaint with the board, or the complainant's designee, shall represent the complainant during the contested case proceedings.

11.21(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.

11.21(5) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

11.21(6) Witnesses may be sequestered during the hearing.

11.21(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.

282—11.22(17A,272) Evidence.

11.22(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.

11.22(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

11.22(3) Evidence in the proceeding shall be confined to the issues concerning allegations raised on the face of the complaint as to which the parties received notice prior to the hearing.

11.22(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.

11.22(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.

11.22(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.

282—11.23(17A,272) Default.

11.23(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.

11.23(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.

11.23(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 282—11.28(17A,272). 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.

11.23(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.

11.23(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 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.

11.23(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.

11.23(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 282—11.26(17A,272).

11.23(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.

11.23(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).

11.23(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 282—11.30(17A,272).

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.24(17A,272) Ex parte communication.

11.24(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 board 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 11.11(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

11.24(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.

11.24(3) Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

11.24(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 282—11.13(17A,272) 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.

11.24(5) Board members acting as presiding officers may communicate with each other without notice or opportunity for parties to participate.

11.24(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 11.24(1).

11.24(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 282—11.19(17A,272).

11.24(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.

11.24(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.

11.24(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 department. Violation of ex parte communication prohibitions by department personnel shall be reported to (agency to designate person to whom violations should be reported) for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

282—11.25(17A,272) Recording costs. Upon request, the board shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

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.

282—11.26(17A,272) Interlocutory appeals. Upon written request of a party or on its own motion, the board may review an interlocutory order of the presiding officer. In determining whether to do so, the board 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 board 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.

282—11.27(17A,272) Final decision.

11.27(1) When the board presides over the reception of evidence at the hearing, its decision is a final decision.

11.27(2) When the board 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 board without further proceedings unless there is an appeal to, or review on motion of, the board within the time provided in rule 282—11.28(17A,272).

282—11.28(17A,272) Appeals and review.

11.28(1) *Appeal by party.* Any adversely affected party may appeal a proposed decision to the board within 30 days after issuance of the proposed decision.

11.28(2) *Review.* The board may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

11.28(3) *Notice of appeal.* An appeal of a proposed decision is initiated by filing a timely notice of appeal with the board. The notice of appeal must be signed by the appealing party or 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.

11.28(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 board may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

11.28(5) *Scheduling.* The board shall issue a schedule for consideration of the appeal.

11.28(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 board may resolve the appeal on the briefs or provide an opportunity for oral argument. The board may shorten or extend the briefing period as appropriate.

282—11.29(17A,272) Applications for rehearing.

11.29(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

11.29(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 board decision on the existing record and whether, on the basis of the grounds enumerated in subrule 11.28(4), the applicant requests an opportunity to submit additional evidence.

11.29(3) *Time of filing.* The application shall be filed with the board within 20 days after issuance of the final decision.

11.29(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

11.29(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

282—11.30(17A,272) Stays of board actions.

11.30(1) *When available.*

a. Any party to a contested case proceeding may petition the board for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the board. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The executive director may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the board 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.

11.30(2) *When granted.* In determining whether to grant a stay, the executive director or presiding officer shall consider the factors listed in Iowa Code section 17A.19(5).

11.30(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the board or any other party.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.31(17A,272) 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.

282—11.32(17A,272) Emergency adjudicative proceedings.

11.32(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 board may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the board by emergency adjudicative order. Before issuing an emergency adjudicative order the board shall consider factors including, but not limited to, the following:

a. Whether there has been a sufficient factual investigation to ensure that the board 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 board is necessary to avoid the immediate danger.

11.32(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 board'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 board;

(3) Certified mail to the last address on file with the board;

(4) First-class mail to the last address on file with the board; 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 board orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the board shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

11.32(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the board shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

11.32(4) *Completion of proceedings.* After the issuance of an emergency adjudicative order, the board 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 board proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further board proceedings to a later date will be granted only in compelling circumstances upon application in writing.

282—11.33(272) Methods of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revoke a practitioner's license, certificate or authorization.
2. Suspend a practitioner's license, certificate or authorization until further order of the board or for a specific period.
3. Prohibit permanently, until further order of the board, or for a specific period, a practitioner from engaging in specified practices, methods, or acts.
4. Require additional education or training.
5. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
6. Issue a public letter of reprimand.
7. Order any other resolution appropriate to the circumstances of the case.

282—11.34(272) Reinstatement. Any person whose license, certificate or authorization to practice has been suspended may apply to the board for reinstatement in accordance with the terms and conditions of the order of the suspension.

11.34(1) All proceedings for reinstatement shall be initiated by the respondent, who shall file with the board an application for reinstatement. Such application shall be docketed in the original case in which the license, certificate or authorization was suspended. All proceedings upon the application for reinstatement shall be subject to the same rules of procedure as other cases before the board.

11.34(2) An application for reinstatement shall allege facts which, if established, will be sufficient to enable the board to determine that the basis for the suspension of the respondent's license, certificate or authorization no longer exists and that it will be in the public interest for the license, certificate or authorization to be reinstated. The burden of proof to establish such facts shall be on the respondent.

11.34(3) An order denying or granting reinstatement shall be based upon a decision which incorporates findings of fact and conclusions of law.

282—11.35(272) Application denial and appeal. The executive director is authorized by Iowa Code section 272.7 to grant or deny applications for licensure. If the executive director denies an application for an initial or exchange license, certificate, or authorization, the executive director shall send to the applicant by regular first-class mail written notice identifying the factual and legal basis for denying the application. If the executive director denies an application to renew an existing license, certificate, or authorization, the provisions of rule 282—11.36(272) shall apply.

11.35(1) *Mandatory grounds for license denial.* The executive director shall deny an application based on the grounds set forth in Iowa Code section 272.2(14), including:

a. The license application is fraudulent.

b. The applicant's license or certification from another state is suspended or revoked.

c. The applicant fails to meet board standards for application or for license renewal.

d. The applicant is less than 21 years of age, except that a coaching authorization or paraeducator certificate may be issued to an applicant who is 18 years of age or older, as provided in Iowa Code sections 272.12 and 272.31. A student enrolled in a practitioner preparation program who meets board

requirements for a temporary, limited purpose license and who is seeking to teach as part of the practicum or internship may be less than 21 years of age.

e. The applicant has been convicted of one of the disqualifying criminal convictions set forth in paragraph 11.35(2)*"a."*

11.35(2) *Conviction of a crime and founded child abuse.*

a. Disqualifying criminal convictions. The board shall deny an application for licensure if the applicant or licensee has been convicted, has pled guilty to, or has been found guilty of the following criminal offenses, regardless of whether the judgment of conviction or sentence was deferred:

(1) Any of the following forcible felonies included in Iowa Code section 702.11: child endangerment, assault, murder, sexual abuse, or kidnapping;

(2) Any of the following criminal sexual offenses, as provided in Iowa Code chapter 709, involving a child:

1. First-, second- or third-degree sexual abuse committed on or with a person who is under the age of 18;
2. Lascivious acts with a child;
3. Assault with intent to commit sexual abuse;
4. Indecent contact with a child;
5. Sexual exploitation by a counselor;
6. Lascivious conduct with a minor;
7. Enticing a minor under Iowa Code section 710.10; or
8. Human trafficking under Iowa Code section 710A.2;

(3) Incest involving a child as prohibited by Iowa Code section 726.2;

(4) Dissemination and exhibition of obscene material to minors as prohibited by Iowa Code section 728.2;

(5) Telephone dissemination of obscene material to minors as prohibited by Iowa Code section 728.15;

(6) Any offense specified in the laws of another jurisdiction, or any offense that may be prosecuted in a federal, military, or foreign court, that is comparable to an offense listed in paragraph 11.35(2)*"a"*; or

(7) Any offense under prior laws of this state or another jurisdiction, or any offense under prior law that was prosecuted in a federal, military, or foreign court, that is comparable to an offense listed in paragraph 11.35(2)*"a."*

b. Other criminal convictions and founded child abuse. When determining whether a person should be denied licensure based on the conviction of any other crime, including a felony, or a founded report of child abuse, the executive director and the board shall consider the following:

(1) The nature and seriousness of the crime or founded abuse in relation to the position sought;

(2) The time elapsed since the crime or founded abuse was committed;

(3) The degree of rehabilitation which has taken place since the crime or founded abuse was committed;

(4) The likelihood that the person will commit the same crime or abuse again;

(5) The number of criminal convictions or founded abuses committed; and

(6) Such additional factors as may in a particular case demonstrate mitigating circumstances or heightened risk to public safety.

11.35(3) *Fraudulent applications.* An application shall be considered fraudulent pursuant to Iowa Code section 272.2(14)*"b"*(3) if it contains any false representation of a material fact or any omission of a material fact which should have been disclosed at the time of application for licensure or is submitted with a false or forged diploma, certificate, affidavit, identification, or other document material to the applicant's qualification for licensure or material to any of the grounds for denial set forth in Iowa Code section 272.2(14).

11.35(4) *Appeal procedure.*

a. An applicant who is aggrieved by the denial of an application for licensure and who desires to challenge the decision of the executive director must appeal the decision and request a hearing before the

board within 30 calendar days of the date the notice of license denial is mailed. An appeal and request for hearing must be in writing and is deemed made on the date of the United States Postal Service nonmetered postmark or the date of personal service to the board office. The request for hearing shall specify the factual or legal errors the applicant contends were made by the executive director, must identify any factual disputes upon which the applicant desires an evidentiary hearing, and may provide additional written information or documents in support of licensure. If a request for hearing is timely made, the executive director shall promptly issue a notice of contested case hearing on the grounds asserted by the applicant.

b. The board, in its discretion, may act as presiding officer at the contested case hearing, may hold the hearing before a panel of three board members, or may request that an administrative law judge act as presiding officer. The applicant may request that an administrative law judge act as presiding officer and render a proposed decision pursuant to rule 282—11.8(17A,272). A proposed decision by a panel of board members or an administrative law judge is subject to appeal or review by the board pursuant to rule 282—11.28(17A,272).

c. Hearings concerning licensure denial shall be conducted according to the contested case procedural rules in this chapter. Evidence supporting the denial of the license may be presented by an assistant attorney general. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

d. On appeal, the board may grant or deny the application for licensure. If the application for licensure is denied, the board shall state the reason or reasons for the denial and may state conditions under which the application could be granted, if applicable.

11.35(5) *Judicial review.* Judicial review of a final order of the board denying licensure may be sought in accordance with the provisions of Iowa Code section 17A.19 which are applicable to judicial review of an agency's final decision in a contested case. In order to exhaust administrative remedies, an applicant aggrieved by the executive director's denial of an application for licensure must timely appeal the adverse decision to the board.

[**ARC 9209B**, IAB 11/3/10, effective 12/8/10; **ARC 0025C**, IAB 3/7/12, effective 4/11/12; **ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.36(272) Denial of renewal application. If the executive director denies an application to renew a license, certificate or authorization, a notice of hearing shall be issued to commence a contested case proceeding. The executive director may deny a renewal application on the same grounds as those that apply to an application for initial or exchange licensure described in subrules 11.35(1) to 11.35(3).

11.36(1) *Hearing procedure.* Hearings on denial of an application to renew a license shall be conducted according to the contested case procedural rules in this chapter. Evidence supporting the denial of the license may be presented by an assistant attorney general. The provisions of subrules 11.35(4) and 11.35(5) shall apply.

11.36(2) *Judicial review.* Judicial review of a final order of the board denying renewal of licensure may be sought in accordance with the provisions of Iowa Code section 17A.19 which are applicable to judicial review of an agency's final decision in a contested case.

11.36(3) *Impact of denial of renewal application.* Pursuant to Iowa Code section 17A.18(2), if the licensee has made timely and sufficient application for renewal, an existing license shall not expire until the last day for seeking judicial review of the board's final order denying the application or a later date fixed by order of the board or reviewing court.

11.36(4) *Timeliness of renewal application.* Within the meaning of Iowa Code section 17A.18(2), a timely and sufficient renewal application shall be:

a. Received by the board on or before the date the license is set to expire or lapse;

b. Signed by the licensee if submitted in paper form or certified as accurate if submitted electronically;

c. Fully completed; and

d. Accompanied by the proper fee. The fee shall be deemed improper if the amount is incorrect, the fee was not included with the application, or the licensee's check is unsigned or returned for insufficient funds.

282—11.37(272) Mandatory reporting of contract nonrenewal or termination or resignation based on allegations of misconduct. The board of directors of a school district or area education agency, the superintendent of a school district or the chief administrator of an area education agency, and the authorities in charge of a nonpublic school shall report to the board the nonrenewal or termination, for reasons of alleged or actual misconduct, of a person's contract executed under Iowa Code sections 279.12, 279.13, 279.15 through 279.21, 279.23, and 279.24, and the resignation of a person who holds a license, certificate, or authorization issued by the board as a result of or following an incident or allegation of misconduct that, if proven, would constitute a violation of 282—subparagraph 25.3(1)*"b"*(1), when the board or reporting official has a good-faith belief that the incident occurred or the allegation is true.

11.37(1) *Method of reporting.* The report required by this rule may be made by completion and filing of the complaint form described in subrule 11.4(2) or by the submission of a letter to the executive director of the board which includes: the full name, address, telephone number, title and signature of the reporter; the full name, address, and telephone number of the person who holds a license, certificate or authorization issued by the board; a concise statement of the circumstances under which the termination, nonrenewal, or resignation occurred; and any additional information or documentation which the reporter believes will be relevant to assessment of the report pursuant to subrule 11.37(4).

11.37(2) *Timely reporting required.* The report required by this rule shall be filed within 60 days of the date of local board action on the termination or resignation.

11.37(3) *Confidentiality of report.* Information reported to the board in accordance with this rule is privileged and confidential, and, except as provided in Iowa Code section 272.13, is not subject to discovery, subpoena, or other means of legal compulsion for its release to a person other than the respondent and the board and its employees and agents involved in licensee discipline, and is not admissible in evidence in a judicial or administrative proceeding other than the proceeding involving licensee discipline.

11.37(4) *Action upon receipt of report.*

a. Upon receipt of a report under this rule, the executive director of the board shall review the information reported to determine whether a complaint investigation should be initiated.

b. In making this determination, the executive director shall consider the nature and seriousness of the reported misconduct in relation to the position sought or held, the time elapsed since the misconduct, the degree of rehabilitation, the likelihood that the individual will commit the same misconduct again, and the number of reported incidents of misconduct.

c. If the executive director determines a complaint should not be initiated, no further formal action will be taken and the matter will be closed.

d. If the executive director determines a complaint investigation should be initiated, the executive director shall assign the matter for investigation pursuant to rule 282—11.5(272).

11.37(5) *Proceedings upon investigation.* From the time of initiation of an investigation, the matter will be processed in the same manner as a complaint filed under rule 282—11.4(17A,272).

282—11.38(256,272) Reporting by department of education employees.

11.38(1) *Method of reporting.* A report of misconduct made by the director, pursuant to Iowa Code section 256.9(52), or made by an employee of the department of education, pursuant to Iowa Code section 272.15(2), shall comply with the requirements of subrule 11.37(1).

11.38(2) *Confidentiality.* Information reported to the board in accordance with this rule is privileged and confidential, except as provided in Iowa Code section 272.13.

11.38(3) *Review and investigation of report.* The report shall be reviewed and investigated pursuant to subrules 11.37(4) and 11.37(5).

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.39(272) Denial of application during a pending professional practices case. The executive director may deny an application for a Class B license if the applicant is currently under investigation and probable cause has been determined by the board.
[**ARC 9659B**, IAB 8/10/11, effective 9/14/11]

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1 Effective date of 282—Ch 11 delayed 45 days by the Administrative Rules Review Committee at its meeting held March 10, 2000; delay lifted by the Committee at its meeting held April 7, 2000, effective April 8, 2000.

2 Two ARCs

3 Effective date of ARC 8406B delayed until the adjournment of the 2010 Session of the General Assembly by the Administrative Rules Review Committee at its meeting held January 5, 2010.

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. Licenses are issued upon application filed on a form provided by the board of educational examiners and upon completion of the following:

13.1(1) *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.

13.1(2) *Iowa division of criminal investigation background check.* An Iowa division of criminal investigation background check will be conducted on initial applicants. The fee for the evaluation of the DCI background check will be assessed to the applicant.

13.1(3) *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, including certification from the applicant of completion of the Praxis II examination, if required; 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. 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 and the board's receipt of verification of completion of the Praxis II examination. 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.

282—13.2(272) Applicants from recognized Iowa institutions. An applicant for initial licensure shall complete either the teacher, administrator, or school service personnel preparation program from a recognized Iowa institution or an alternative program recognized by the Iowa board of educational examiners. A recognized Iowa institution is one which has its program of preparation approved by the state board of education according to standards established by said board, or an alternative program recognized by the state board of educational examiners. Applicants shall complete the requirements set out in rule 282—13.1(272) and shall also have the recommendation for the specific license and endorsement(s) or the specific endorsement(s) from the designated recommending official at the recognized education institution where the preparation was completed.

282—13.3(272) Applicants from non-Iowa institutions.

13.3(1) *Requirements for applicants from non-Iowa institutions.* An applicant for licensure who completes the teacher, administrator, or school service personnel preparation program from a non-Iowa institution shall verify the requirements of either subrule 13.18(4) or 13.18(5).

13.3(2) *Requirements for applicants from non-Iowa traditional teacher preparation programs.* Provided all requirements for Iowa licensure have been met through a state-approved regionally accredited teacher education program at the graduate or undergraduate level in which college or university credits were given and student teaching was required, the applicant shall:

a. Provide a recommendation for the specific license and endorsement(s) from the designated recommending official at the recognized institution where the preparation was completed, and

b. Submit a copy of a valid regular teaching certificate or license exclusive of a temporary, emergency or substitute license or certificate, and

c. Provide verification of successfully passing mandated tests in the state in which the applicant is currently licensed if the applicant has fewer than three years of teaching experience.

13.3(3) *Requirements for applicants from out-of-state nontraditional teacher preparation programs.* An applicant who holds a valid license from another state and whose preparation was completed through a state-approved nontraditional teacher preparation program must:

a. Hold a baccalaureate degree with a minimum cumulative grade point average of 2.50 on a 4.0 scale from a regionally accredited institution.

b. Provide a valid out-of-state teaching license based on a state-approved nontraditional teacher preparation program.

c. Provide a recommendation from a regionally accredited institution, department of education, or a state's standards board indicating the completion of an approved nontraditional teacher preparation program.

d. Provide an official institutional transcript(s) to be analyzed for the requirements necessary for full Iowa licensure based on 13.9(4)*"a"*(1) to (7), 13.9(4)*"c"*(1) to (5), 13.18(2), 282—13.28(272), and 282—14.2(272).

e. Meet the recency requirements listed in 13.10(3).

f. If the applicant has fewer than three years of teaching experience, provide verification from the state licensing agency/department in the state where the nontraditional teacher preparation program was completed indicating that the applicant has successfully passed that state's mandated tests.

g. Complete a student teaching or internship experience or verify three years of teaching experience.

h. If through a transcript analysis the professional education core requirements set forth in 13.9(4)*"a"*(1) to (7), 13.9(4)*"c"*(1) to (5), and 13.18(2) and the content endorsement requirements pursuant to 282—13.28(272) may be identified by course titles, published course descriptions, and grades, then the transcripts will be reviewed to determine the applicant's eligibility for an Iowa teaching license. However, if the professional education core requirements of 13.9(4)*"a"*(1) to (7), 13.9(4)*"c"*(1) to (5), and 13.18(2) and the content endorsement requirements cannot be reviewed in this manner, a portfolio review and evaluation process will be utilized.

13.3(4) *Portfolio review and evaluation process.* An applicant whose professional education core requirements pursuant to 13.9(4)*"a"*(1) to (7), 13.9(4)*"c"*(1) to (5), and 13.18(2) or whose content endorsement requirements for special education (282—subrule 14.2(2)) could not be reviewed through transcript analysis may submit to the board a portfolio in the approved format for review and evaluation.

a. An applicant must demonstrate proficiency in seven of the nine standards in the Iowa professional education core, set forth in 13.18(4)*"a"* to *"i,"* to be eligible to receive a license.

b. An applicant must have completed at least 75 percent of the endorsement requirements through a two- or four-year institution in order for the endorsement to be included on the license. An applicant who does not have at least 75 percent of one content endorsement area as described in 282—13.28(272) completed will not be issued a license.

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

d. Any deficiencies in the professional education core as set forth in 13.18(4)*"a"* to *"i"* or in the special education content endorsement area that are identified during the portfolio review and evaluation process shall be met through coursework with course credits completed at a state-approved, regionally accredited institution or through courses approved by the executive director. Other content deficiencies may be met through coursework in a two- or four-year institution in which course credits are given.

13.3(5) *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 13.3(4)*"a,"* 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.

[**ARC 8139B**, IAB 9/9/09, effective 10/14/09; **ARC 8610B**, IAB 3/10/10, effective 4/14/10]

282—13.4(272) Applicants from foreign institutions. An applicant for initial licensure whose preparation was completed in a foreign institution must 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 board of educational examiners for a determination of eligibility for licensure.

282—13.5(272) Teacher licenses. A license may be issued to applicants who fulfill 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 which meets the requirements of the professional education core.

c. Have completed an approved human relations component.

d. Have completed the exceptional learner component.

e. Have completed the requirements for one of the basic teaching endorsements.

f. Meet the recency requirement of subrule 13.10(3).

13.5(2) *Renewal requirements.* Renewal requirements for teacher licenses are set out in 282—Chapter 20.

282—13.6(272) Specific requirements for an initial license. An initial license valid for two years may be issued to an applicant who meets the general requirements set forth in subrule 13.5(1).

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 subrule 13.5(1), and
2. Shows evidence of successful completion of a state-approved mentoring and induction program by meeting the Iowa teaching standards as determined by a comprehensive evaluation and two years' successful teaching experience. In lieu of completion of an Iowa state-approved mentoring and induction program, the applicant must provide evidence of three years' successful teaching experience in an Iowa nonpublic school or three years' successful teaching experience in an out-of-state K-12 educational setting.

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 in a recognized endorsement area, or
- Master's degree in curriculum, effective teaching, or a similar degree program which has a focus on school curriculum or instruction.

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 year from the date of issuance. This license is nonrenewable. The fee for the teacher intern license is in 282—Chapter 12.

13.9(3) *Teacher intern requirements.* A teacher intern license shall be issued upon application provided that the following requirements have been met. The applicant shall:

a. Hold a baccalaureate degree with a minimum cumulative grade point average of 2.50 on a 4.0 scale from a regionally accredited institution.

b. Meet the requirements of at least one of the board's secondary (5-12) teaching endorsements listed in rule 282—13.28(272).

c. Possess a minimum of three years of postbaccalaureate work experience. An authorized official at a college or university with an approved teacher intern program will evaluate this experience.

d. Successfully complete the teacher intern program requirements listed in subrule 13.9(4) and approved by the state board of education.

e. Successfully pass a basic skills test at the level approved by the teacher education institution.

13.9(4) *Program requirements.* The teacher intern shall:

a. Complete the following requirements prior to the internship year:

(1) Learning environment/classroom management. The intern uses 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) Instructional planning. The intern plans instruction based upon knowledge of subject matter, students, the community, curriculum goals, and state curriculum models.

(3) Instructional strategies. The intern understands and uses a variety of instructional strategies to encourage students' development of critical thinking, problem solving, and performance skills.

(4) Student learning. The intern understands how students learn and develop and provides learning opportunities that support intellectual, career, social, and personal development.

(5) Diverse learners. The intern understands how students differ in their approaches to learning and creates instructional opportunities that are equitable and are adaptable to diverse learners.

(6) Collaboration, ethics and relationships. The intern fosters relationships with parents, school colleagues, and organizations in the larger community to support students' learning and development.

(7) Assessment. The intern understands and uses formal and informal assessment strategies to evaluate the continuous intellectual, social, and physical development of the learner.

(8) Field experiences that provide opportunities for interaction with students in an environment that supports learning in context. These experiences shall total at least 50 contact hours in the field prior to the beginning of the academic year of the candidate's initial employment as a teacher intern.

b. Complete four semester hours of a teacher intern seminar during the teacher internship year to include support and extension of coursework from the teacher intern program.

c. Complete the coursework and competencies in the following areas:

(1) Foundations, reflection, and professional development. The intern continually evaluates the effects of the practitioner's choices and actions on students, parents, and other professionals in the learning community and actively seeks out opportunities to grow professionally.

(2) Communication. The intern uses knowledge of effective verbal, nonverbal, and media communication techniques, and other forms of symbolic representation, to foster active inquiry and collaboration and to support interaction in the classroom.

(3) Exceptional learner program, which must include preparation that contributes to the education of individuals with disabilities and the gifted and talented.

(4) Preparation in the integration of reading strategies into the content area.

(5) Computer technology related to instruction.

(6) An advanced study of the items set forth in 13.9(4)*"a"*(1) to (7) above.

13.9(5) *Local school district requirements.* The local school district shall:

a. Provide an offer of employment to an individual who has been evaluated by a college or university for eligibility or acceptance in the teacher intern program.

b. Participate in a mentoring and induction program.

c. Provide a district mentor for the teacher intern.

d. Provide other support and supervision, as needed, to maximize the opportunity for the teacher intern to succeed.

e. Not overload the teacher intern with extracurricular duties not directly related to the teacher intern's teaching assignment.

f. Provide evidence to the board from a licensed evaluator that the teacher intern is participating in a mentoring and induction program.

g. At the board's request, provide information including, but not limited to, the teacher intern selection and preparation program, institutional support, local school district mentor, and local school district support.

13.9(6) *Requirements to convert the teacher intern license to the initial license.*

a. An initial license shall be issued upon application provided that the teacher intern has met all of the following requirements:

(1) Successful completion of the coursework and competencies in the teacher intern program approved by the state board of education.

(2) Verification from a licensed evaluator that the teacher intern served successfully for a minimum of 160 days.

(3) Verification from a licensed evaluator that the teacher intern is participating in a mentoring and induction program and is being assessed on the Iowa teaching standards.

(4) Recommendation by a college or university offering an approved teacher intern program that the individual is eligible for an initial license.

(5) At the board's request, the teacher intern shall provide to the board information including, but not limited to, the teacher intern selection and preparation program, institutional support, local school district mentor, and local school district support.

b. The teacher intern year will count as one of the years that is needed for the teacher intern to convert the initial license to the standard license if the conditions listed in paragraph 13.9(6)*"a"* have been met.

13.9(7) *Requirements to obtain the initial license if the teacher intern does not complete the internship year.*

a. An initial license shall be issued upon application provided that the teacher intern has met the requirements for one of the following options:

(1) Option #1:

1. Successful completion of the coursework and competencies in the teacher intern program approved by the state board of education; and

2. Verification by a college or university that the teacher intern successfully completed the college's or university's state-approved student teaching requirements; and

3. Recommendation by a college or university offering an approved teacher intern program that the individual is eligible for an initial license.

(2) Option #2:

1. Successful completion of the coursework and competencies in the teacher intern program approved by the state board of education; and

2. Verification by the approved teacher intern program that the teacher intern successfully completed 40 days of paid substitute teaching; and

3. Verification by the teacher intern program that the teacher intern successfully completed 40 days of co-teaching; and

4. Recommendation by the approved teacher intern program that the individual is eligible for an initial license.

b. At the board's request, the teacher intern shall provide to the board information including, but not limited to, the teacher intern selection and preparation program, institutional support, local school district mentor, and local school district support.

13.9(8) *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 160 days 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]

282—13.10(272) Specific requirements for a Class A license. A nonrenewable Class A license valid for one year may be issued to an individual who has completed a teacher education program under any one of the following conditions:

13.10(1) *Professional core requirements.* The individual has not completed all of the required courses in the professional core, 13.18(4)*"a"* through *"j."*

13.10(2) *Human relations component.* The individual has not completed an approved human relations component.

13.10(3) *Recency.* The individual meets the requirements for a valid license, but has had fewer than 160 days of teaching experience during the five-year period immediately preceding the date of application or has not completed six semester hours of college credit from a recognized institution within the five-year period. To obtain the desired license, the applicant must complete recent credits and, where recent credits are required, these credits shall be taken in professional education or in the applicant's endorsement area(s).

13.10(4) *Degree not granted until next regular commencement.* Rescinded IAB 9/9/09, effective 10/14/09.

13.10(5) *Based on an expired Iowa certificate or license, exclusive of a Class A or Class B license.*

a. The holder of an expired license, exclusive of a Class A or Class B license, shall be eligible to receive a Class A 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(6) *Based on a mentoring and induction program.* An applicant may be eligible for a Class A 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.

13.10(7) *Based on an administrative decision.* The executive director is authorized to issue a Class A license to an applicant whose services are needed to fill positions in unique need circumstances.

[**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]

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 (one-year extension of an initial, standard, or master educator), 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 for special education endorsement.* The college or university must outline the program of study necessary to meet the special education endorsement requirements. This program of study must be attached to the application.

13.11(3) *Request for exception.* A school district administrator may file a written request with the board for an exception to the minimum content requirements 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.

13.11(4) *Provisional occupational license.* If an individual is eligible for a provisional occupational license but has not met all of the experience requirements, a Class B license may be issued while the individual earns the necessary experience.

13.11(5) *Expiration.* This 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]

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 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, Class B, or teacher exchange license, the holder of the expired license shall be eligible to receive a Class E 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 license. The Class E 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]

282—13.15(272) Specific requirements for a Class G license. A nonrenewable Class G license valid for one year may be issued to an individual who must complete a school guidance counseling practicum or internship in an approved program in preparation for the school guidance counselor endorsement. The Class G license may be issued under the following limited conditions:

1. Verification of a baccalaureate degree from a regionally accredited institution.
2. Verification from the institution that the individual is admitted and enrolled in an approved school guidance counseling program.
3. Verification that the individual has completed the coursework and competencies required prior to the practicum or internship.
4. Written documentation of the requirements listed in "1" to "3" above, provided by the official at the institution where the individual is completing the approved school guidance counseling program and forwarded to the Iowa board of educational examiners with the application form for licensure.

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:

a. Has been the holder of, or presently holds, a license in Iowa; or holds or held a regular teacher's license or certificate in another state, exclusive of temporary, emergency, or substitute certificate or license, or a certificate based on an alternative certification program; or

b. Has successfully completed all requirements of an approved teacher education program, but did not apply for an Iowa teacher's license at the time of completion of the approved program.

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 teach in any school system in any position in which a regularly licensed teacher was employed to begin the school year except in the driver's education classroom. In addition to the authority inherent in the initial, standard, master educator, professional administrator, two-year exchange, 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.
[**ARC 9205B**, IAB 11/3/10, effective 12/8/10; **ARC 9206B**, IAB 11/3/10, effective 12/8/10]

282—13.17(272) Specific requirements for exchange licenses. An applicant seeking Iowa licensure who completes the teacher preparation program from a recognized non-Iowa institution shall verify the requirements of subrules 13.18(4) and 13.18(5) through traditional course-based preparation program and transcript review. A recognized non-Iowa teacher preparation institution is one that is state-approved and is accredited by the regional accrediting agency for the territory in which the institution is located. Applicants for nontraditional exchange licenses are not required to have received their preparation through regionally approved teacher education programs.

13.17(1) *One-year teacher exchange license.*

a. For an applicant applying under 13.3(2), a one-year nonrenewable exchange license may be issued to the applicant under the following conditions:

(1) The applicant has completed a state-approved, regionally accredited teacher education program; and

(2) The applicant has the recommendation for the specific license and endorsement(s) from the designated recommending official at the recognized non-Iowa institution where the preparation was completed; and

(3) The applicant holds and submits a copy of a valid and current certificate or license in the state in which the preparation was completed or in which the applicant is currently teaching, exclusive of a temporary, emergency or substitute license or certificate;

1. If the applicant's out-of-state license is expired, a one-year teacher exchange license may be issued and the lack of a valid and current out-of-state license will be listed as a deficiency;

2. If 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, a regional exchange license may be issued and the lack of a valid and current out-of-state license will be listed as a deficiency; and

(4) If the applicant has fewer than three years of teaching experience or is being recommended for a K-6 elementary education endorsement, the applicant must verify successful completion of mandated tests in the state in which the applicant is currently licensed; and

(5) Each exchange license shall be limited to the area(s) and level(s) of instruction as determined by an analysis of the application, the transcripts and the license or certificate held in the state in which the basic preparation for licensure was completed or of the application and the credential evaluation report. The applicant must have completed at least 75 percent of the endorsement requirements through a two- or four-year institution in order for the endorsement to be included on the exchange license; and

(6) The applicant is not subject to any pending disciplinary proceedings in any state or country; and

(7) The applicant complies with all requirements with regard to application processes and payment of licensure fees.

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.

c. If the lack of a valid and current out-of-state license was listed as a deficiency, the one-year teacher exchange license shall not be converted or extended until a valid and current out-of-state license is presented to remove the deficiency.

13.17(2) *Two-year nontraditional exchange license.* For an applicant applying under 13.3(3) and 13.3(4), a two-year nontraditional teacher exchange license may be issued to the applicant from state-approved preparation programs, under the following conditions:

a. The applicant has met the requirements of 13.3(4)*"a"* and *"b."*

b. The applicant has met the requirements of 13.17(1)*"a"*(3) through (7).

c. To convert the two-year nontraditional exchange license, the applicant must meet all deficiencies as well as meet the Iowa teaching standards as determined by a comprehensive evaluation by a licensed evaluator, and the applicant shall have two years of successful teaching experience in

Iowa. The evaluator may recommend extending the license for a third year to meet Iowa teaching standards.

d. The license may be extended to meet the requirements for two years of successful teaching in Iowa with proof of employment.

13.17(3) *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 not subject to any pending disciplinary proceedings in any state or country; and

(3) The applicant complies with all requirements with regard to application processes and payment of licensure fees; and

(4) The applicant is a participant in a teacher exchange program administered through the Iowa department of education.

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 three years.

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.

[**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]

282—13.18(272) General requirements for an original teaching subject area endorsement. Following are the general requirements for the issuance of a license with an endorsement.

13.18(1) Baccalaureate degree from a regionally accredited institution.

13.18(2) Completion of an approved human relations component.

13.18(3) Completion of the exceptional learner program, which must include preparation that contributes to the education of individuals with disabilities and the gifted and talented.

13.18(4) Professional education core. Completed coursework or evidence of competency in:

a. Student learning. The practitioner understands how students learn and develop, and provides learning opportunities that support intellectual, career, social and personal development.

b. Diverse learners. The practitioner understands how students differ in their approaches to learning and creates instructional opportunities that are equitable and are adaptable to diverse learners.

c. Instructional planning. The practitioner plans instruction based upon knowledge of subject matter, students, the community, curriculum goals, and state curriculum models.

d. Instructional strategies. The practitioner understands and uses a variety of instructional strategies to encourage students' development of critical thinking, problem solving, and performance skills.

e. Learning environment/classroom management. The practitioner uses 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.

f. Communication. The practitioner uses knowledge of effective verbal, nonverbal, and media communication techniques, and other forms of symbolic representation, to foster active inquiry, collaboration, and support interaction in the classroom.

g. Assessment. The practitioner understands and uses formal and informal assessment strategies to evaluate the continuous intellectual, social, and physical development of the learner.

h. Foundations, reflection and professional development. The practitioner continually evaluates the effects of the practitioner's choices and actions on students, parents, and other professionals in the learning community, and actively seeks out opportunities to grow professionally.

i. Collaboration, ethics and relationships. The practitioner fosters relationships with parents, school colleagues, and organizations in the larger community to support students' learning and development.

j. Computer technology related to instruction.

k. Completion of pre-student teaching field-based experiences.

l. Methods of teaching with an emphasis on the subject and grade level endorsement desired.

m. Student teaching in the subject area and grade level endorsement desired.

n. Preparation in reading programs, including reading recovery, and integration of reading strategies into content area methods coursework.

13.18(5) Content/subject matter specialization. The practitioner understands the central concepts, tools of inquiry, and structure of the discipline(s) the practitioner teaches and creates learning experiences that make these aspects of subject matter meaningful for students. This is evidenced by completion of a 30-semester-hour teaching major which must minimally include the requirements for at least one of the basic endorsement areas, special education teaching endorsements, or secondary level occupational endorsements.

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

282—13.20 Reserved.

282—13.21(272) Human relations requirements for practitioner licensure. Preparation in human relations shall be included in programs leading to teacher licensure. Human relations study shall include interpersonal and intergroup relations and shall contribute to the development of sensitivity to and understanding of the values, beliefs, lifestyles and attitudes of individuals and the diverse groups found in a pluralistic society.

13.21(1) Beginning on or after August 31, 1980, each applicant for an initial practitioner's license shall have completed the human relations requirement.

13.21(2) On or after August 31, 1980, each applicant for the renewal of a practitioner's license shall have completed an approved human relations requirement.

13.21(3) Credit for the human relations requirement shall be given for licensed persons who can give evidence that they have completed a human relations program which meets board of educational examiners criteria (see rule 282—13.22(272)).

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—13.22(272) Development of human relations components. Human relations components shall be developed by teacher preparation institutions. In-service human relations components may also be developed by educational agencies other than teacher preparation institutions, as approved by the board of educational examiners.

13.22(1) *Advisory committee.* Education agencies developing human relations components shall give evidence that in the development of their programs they were assisted by an advisory committee. The advisory committee shall consist of equal representation of various minority and majority groups.

13.22(2) *Standards for approved components.* Human relations components will be approved by the board of educational examiners upon submission of evidence that the components are designed to develop the ability of participants to:

a. Be aware of and understand the values, lifestyles, history, and contributions of various identifiable subgroups in our society.

b. Recognize and deal with dehumanizing biases such as sexism, racism, prejudice, and discrimination and become aware of the impact that such biases have on interpersonal relations.

c. Translate knowledge of human relations into attitudes, skills, and techniques which will result in favorable learning experiences for students.

d. Recognize the ways in which dehumanizing biases may be reflected in instructional materials.

e. Respect human diversity and the rights of each individual.

f. Relate effectively to other individuals and various subgroups other than one's own.

13.22(3) *Evaluation.* Educational agencies providing the human relations components shall indicate the means to be utilized for evaluation.

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.

b. Program requirements.

(1) Degree—baccalaureate, and

(2) Completion of an approved human relations program, and

(3) Completion of the professional education core. See subrule 13.18(3).

c. Content.

(1) Human growth and development: infancy and early childhood, unless completed as part of the professional education core. See subrule 13.18(4).

(2) Curriculum development and methodology for young children.

(3) Child-family-school-community relationships (community agencies).

(4) Guidance of young children three to six years of age.

(5) Organization of prekindergarten-kindergarten programs.

(6) Child and family nutrition.

(7) Language development and learning.

(8) Kindergarten: programs and curriculum development.

13.26(2) *Teacher—prekindergarten through grade three.*

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

b. Program requirements.

(1) Degree—baccalaureate.

(2) Completion of an approved human relations program.

(3) Completion of the professional education core. See subrules 13.18(3) and 13.18(4).

(4) Highly qualified teacher (HQT) status. Applicants from non-Iowa institutions who have completed the requirements for this endorsement must verify their HQT status. The board shall determine the test and the minimum passing score for HQT status. Verification must be provided through one of the following:

1. Written verification from the department of education in the state in which the applicant completed the elementary teacher preparation program that the applicant has achieved HQT status in that state; or

2. Written verification from the department of education in the state where the applicant is currently teaching that the applicant has achieved HQT status in that state; or

3. Submission of the official test score report indicating the applicant has met the qualifying score for licensure in the state in which the applicant completed the elementary teacher preparation program; or

4. Obtaining the qualifying score set by the Iowa board of educational examiners if the applicant has not been teaching within the last five years and completion of a teacher preparation program prior to enactment of the federal highly qualified teacher legislation (June 2006). This option may also be utilized by applicants from outside the United States.

5. For applicants who have completed the requirements for one of the Iowa elementary endorsements, verification of HQT status by meeting the minimum score set by the Iowa board of educational examiners if the applicant has not been teaching within the last five years and completion of a teacher preparation program prior to enactment of the federal highly qualified teacher legislation (June 2006). This option may also be utilized by applicants who have been teaching outside the United States.

c. Content.

(1) Child growth and development with emphasis on cognitive, language, physical, social, and emotional development, both typical and atypical, for infants and toddlers, preprimary, and primary

school children (grades one through three), unless combined as part of the professional education core. See subrule 13.18(4) of the licensure rules for the professional core.

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

(3) Developmentally appropriate curriculum with emphasis on integrated multicultural and nonsexist content including language, mathematics, science, social studies, health, safety, nutrition, visual and expressive arts, social skills, higher-thinking skills, and developmentally appropriate methodology, including adaptations for individual needs, for infants and toddlers, preprimary, and primary school children.

(4) Characteristics of play and creativity, and their contributions to the cognitive, language, physical, social and emotional development and learning of infants and toddlers, preprimary, and primary school children.

(5) Classroom organization and individual interactions to create positive learning environments for infants and toddlers, preprimary, and primary school children based on child development theory emphasizing guidance techniques.

(6) Observation and application of developmentally appropriate assessments for infants and toddlers, preprimary, and primary school children recognizing, referring, and making adaptations for children who are at risk or who have exceptional educational needs and talents.

(7) Home-school-community relationships and interactions designed to promote and support parent, family and community involvement, and interagency collaboration.

(8) Family systems, cultural diversity, and factors which place families at risk.

(9) Child and family health and nutrition.

(10) Advocacy, legislation, and public policy as they affect children and families.

(11) Administration of child care programs to include staff and program development and supervision and evaluation of support staff.

(12) Pre-student teaching field experience with three age levels in infant and toddler, preprimary, and primary programs, with no less than 100 clock hours, and in different settings, such as rural and urban, socioeconomic status, cultural diversity, program types, and program sponsorship.

(13) Student teaching experiences with two different age levels, one before kindergarten and one from kindergarten through grade three.

13.26(3) *Teacher—prekindergarten through grade three, including special education.*

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

b. Program requirements.

(1) Degree—baccalaureate, and

(2) Completion of an approved human relations program, and

(3) Completion of the professional education core. See subrules 13.18(3) and 13.18(4).

(4) Highly qualified teacher (HQT) status. Applicants from non-Iowa institutions who have completed the requirements for this endorsement must verify their HQT status. The board shall determine the test and the minimum passing score for HQT status. Verification must be provided through one of the following:

1. Written verification from the department of education in the state in which the applicant completed the elementary teacher preparation program that the applicant has achieved HQT status in that state; or

2. Written verification from the department of education in the state where the applicant is currently teaching that the applicant has achieved HQT status in that state; or

3. Submission of the official test score report indicating the applicant has met the qualifying score for licensure in the state in which the applicant completed the elementary teacher preparation program; or

4. Obtaining the qualifying score set by the Iowa board of educational examiners if the applicant has not been teaching within the last five years and completion of a teacher preparation program prior to enactment of the federal highly qualified teacher legislation (June 2006). This option may also be utilized by applicants from outside the United States.

5. For applicants who have completed the requirements for one of the Iowa elementary endorsements, verification of HQT status by meeting the minimum score set by the Iowa board of educational examiners if the applicant has not been teaching within the last five years and completion of a teacher preparation program prior to enactment of the federal highly qualified teacher legislation (June 2006). This option may also be utilized by applicants who have been teaching outside the United States.

c. Content.

(1) Child growth and development.

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, aesthetics, and adaptive behavior.

2. Understand individual differences in development and learning including risk factors, developmental variations and developmental patterns of specific disabilities and special abilities.

3. Recognize that children are best understood in the contexts of family, culture and society and that cultural and linguistic diversity influences development and learning.

(2) Developmentally appropriate learning environment and curriculum implementation.

1. Establish learning environments with social support, from the teacher and from other students, for all children to meet their optimal potential, with a climate characterized by mutual respect, encouraging and valuing the efforts of all regardless of proficiency.

2. Appropriately use informal and formal assessment to monitor development of children and to plan and evaluate curriculum and teaching practices to meet individual needs of children and families.

3. Plan, implement, and continuously evaluate developmentally and individually appropriate curriculum goals, content, and teaching practices for infants, toddlers, preprimary and primary children based on the needs and interests of individual children, their families and community.

4. Use both child-initiated and teacher-directed instructional methods, including strategies such as small and large group projects, unstructured and structured play, systematic instruction, group discussion and cooperative decision making.

5. Develop and implement integrated learning experiences for home-, center- and school-based environments for infants, toddlers, preprimary and primary children.

6. Develop and implement integrated learning experiences that facilitate cognition, communication, social and physical development of infants and toddlers within the context of parent-child and caregiver-child relationships.

7. Develop and implement learning experiences for preprimary and primary children with focus on multicultural and nonsexist content that includes development of responsibility, aesthetic and artistic development, physical development and well-being, cognitive development, and emotional and social development.

8. Develop and implement learning experiences for infants, toddlers, preprimary, and primary children with a focus on language, mathematics, science, social studies, visual and expressive arts, social skills, higher-thinking skills, and developmentally appropriate methodology.

9. Develop adaptations and accommodations for infants, toddlers, preprimary, and primary children to meet their individual needs.

10. Adapt materials, equipment, the environment, programs and use of human resources to meet social, cognitive, physical motor, communication, and medical needs of children and diverse learning needs.

(3) Health, safety and nutrition.

1. Design and implement physically and psychologically safe and healthy indoor and outdoor environments to promote development and learning.

2. Promote nutritional practices that support cognitive, social, cultural and physical development of young children.

3. Implement appropriate appraisal and management of health concerns of young children including procedures for children with special health care needs.

4. Recognize signs of emotional distress, physical and mental abuse and neglect in young children and understand mandatory reporting procedures.

5. Demonstrate proficiency in infant-child cardiopulmonary resuscitation, emergency procedures and first aid.

(4) Family and community collaboration.

1. Apply theories and knowledge of dynamic roles and relationships within and between families, schools, and communities.

2. Assist families in identifying resources, priorities, and concerns in relation to the child's development.

3. Link families, based on identified needs, priorities and concerns, with a variety of resources.

4. Use communication, problem-solving and help-giving skills in collaboration with families and other professionals to support the development, learning and well-being of young children.

5. Participate as an effective member of a team with other professionals and families to develop and implement learning plans and environments for young children.

(5) Professionalism.

1. Understand legislation and public policy that affect all young children, with and without disabilities, and their families.

2. Understand legal aspects, historical, philosophical, and social foundations of early childhood education and special education.

3. 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 and evaluation of staff, and continuing improvement of programs and services.

4. Identify current trends and issues of the profession to inform and improve practices and advocate for quality programs for young children and their families.

5. Adhere to professional and ethical codes.

6. Engage in reflective inquiry and demonstration of professional self-knowledge.

(6) Pre-student teaching field experiences. Complete 100 clock hours of pre-student teaching field experience with three age levels in infant and toddler, preprimary, and primary programs and in different settings, such as rural and urban, encompassing differing socioeconomic status, ability levels, cultural and linguistic diversity and program types and sponsorship.

(7) Student teaching. Complete a supervised student teaching experience of a total of at least 12 weeks in at least two different classrooms which include children with and without disabilities in two of three age levels: infant and toddler, preprimary, and primary.

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. Program requirements.

(1) Degree—baccalaureate, and

(2) Completion of an approved human relations component, and

(3) Completion of the professional education core. See subrules 13.18(3) and 13.18(4).

(4) Highly qualified teacher (HQT) status. Applicants from non-Iowa institutions who have completed the requirements for this endorsement must verify their HQT status. The board shall determine the test and the minimum passing score for HQT status. Verification must be provided through one of the following:

1. Written verification from the department of education in the state in which the applicant completed the elementary teacher preparation program that the applicant has achieved HQT status in that state; or

2. Written verification from the department of education in the state where the applicant is currently teaching that the applicant has achieved HQT status in that state; or

3. Submission of the official test score report indicating the applicant has met the qualifying score for licensure in the state in which the applicant completed the elementary teacher preparation program; or

4. Obtaining the qualifying score set by the Iowa board of educational examiners if the applicant has not been teaching within the last five years and completion of a teacher preparation program prior to enactment of the federal highly qualified teacher legislation (June 2006). This option may also be utilized by applicants from outside the United States.

5. For applicants who have completed the requirements for one of the Iowa elementary endorsements, verification of HQT status by meeting the minimum score set by the Iowa board of educational examiners if the applicant has not been teaching within the last five years and completion of a teacher preparation program prior to enactment of the federal highly qualified teacher legislation (June 2006). This option may also be utilized by applicants who have been teaching outside the United States.

c. 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. See subrule 13.18(4).

(2) Methods and materials of teaching elementary language arts.

(3) Methods and materials of teaching elementary reading.

(4) Elementary curriculum (methods and materials).

(5) Methods and materials of teaching elementary mathematics.

(6) Methods and materials of teaching elementary science.

(7) Children's literature.

(8) Methods and materials of teaching elementary social studies.

(9) Methods and materials in two of the following areas:

1. Methods and materials of teaching elementary health.
2. Methods and materials of teaching elementary physical education.
3. Methods and materials of teaching elementary art.
4. Methods and materials of teaching elementary music.

(10) Pre-student teaching field experience in at least two different grades.

(11) A field of specialization in a single discipline or a formal interdisciplinary program of at least 12 semester hours.

13.26(5) *Teacher—elementary classroom.* Effective September 1, 2015, the following requirements apply to persons who wish to teach in the elementary classroom:

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

b. Program requirements.

(1) Degree—baccalaureate, and

(2) Completion of an approved human relations component, and

(3) Completion of the professional education core. See subrules 13.18(3) and 13.18(4).

c. 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. See subrule 13.18(4).

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

1. Content:

- Children's literature;
- Oral and written communication skills for the twenty-first century.

2. Methods:

- Assessment, diagnosis and evaluation of student learning in literacy;
- 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 approaches of literacy instruction;
- 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.

[**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]

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 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) or 282—subrules 17.1(1) and 17.1(3).

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 in subrule 13.18(4).

(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 in subrule 13.18(4).

(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.

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. Individuals who were licensed in Iowa prior to October 1, 1988, and were allowed to teach marketing without completing the endorsement requirements must complete the endorsement requirements by July 1, 2010, in order to teach or continue to teach marketing. A waiver provision is available through the board of educational examiners for individuals who have been successfully teaching marketing.

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) *Foreign language.* K-8 and 5-12. Completion of 24 semester hours in each foreign 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, consumer health, substance abuse, family life education, mental/emotional health, and human nutrition.

13.28(9) *Family and consumer sciences—general.* 5-12. Completion of 24 semester hours in family and consumer sciences to include coursework in human development, parenthood education, family studies, consumer resource management, textiles and apparel, housing, and foods and nutrition.

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.

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.

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.

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, adapted physical education, physical education in the elementary school, human growth and development of children related to physical education, and first aid and emergency care.

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, adapted physical education, curriculum and administration of physical education, assessment processes in physical education, and first aid and emergency care.

13.28(15) *Reading.*

a. K-8 requirements. Completion of 24 semester hours in reading to include all of the following requirements:

(1) Foundations of reading. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of the psychological, sociocultural, 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 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.

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

(2) Reading in the content areas. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of text structure and the dimensions of content area vocabulary and comprehension, including literal, interpretive, critical, and evaluative.

2. The practitioner provides content area instruction in reading and writing that effectively uses a variety of research-based strategies and practices.

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

1. The practitioner works with 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.

(4) Language development. This requirement includes the following competency: The practitioner uses knowledge of language development and acquisition of reading skills (birth through sixth grade), and the variations related to cultural and linguistic diversity to provide effective instruction in reading and writing.

(5) Oral communication. 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 Standard English by all learners.

(6) Written communication. This requirement includes the following competency: The practitioner uses knowledge of reading-writing-speaking connections; the writing process; 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.

(7) Reading assessment, diagnosis and evaluation. This requirement includes the following competencies:

1. The practitioner uses knowledge of a variety of instruments, procedures, and practices that range from individual to group and from formal to informal to alternative for the identification of students' reading proficiencies and needs, for planning and revising instruction for all students, and for communicating the results of ongoing assessments to all stakeholders.

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

(8) Children's nonfiction and fiction. This requirement includes the following competency: The practitioner uses knowledge of children's literature 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.

(9) Reading instructional strategies. This requirement includes the following competency: The practitioner uses knowledge of a range of research-based strategies and instructional technology for designing and delivering effective instruction across the curriculum, for grouping students, and for selecting materials appropriate for learners at various stages of reading and writing development and from varied cultural and linguistic backgrounds.

b. 5-12 requirements. Completion of 24 semester hours in reading to include all of the following requirements:

(1) Foundations of reading. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of the psychological, sociocultural, 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 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.

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

(2) Reading in the content areas. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of text structure and the dimensions of content area vocabulary and comprehension, including literal, interpretive, critical, and evaluative.

2. The practitioner provides content area instruction in reading and writing that effectively uses a variety of research-based strategies and practices.

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

1. The practitioner works with 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 students' reading and writing development.

(4) Language development. This requirement includes the following competency: The practitioner uses knowledge of the relationship of language acquisition and language development with the

acquisition and development of reading skills, and the variations related to cultural and linguistic diversity to provide effective instruction in reading and writing.

(5) Oral communication. This requirement includes the following competency: The practitioner demonstrates knowledge of the unique needs and backgrounds of students with language differences and uses effective strategies for facilitating the learning of Standard English by all learners.

(6) Written communication. This requirement includes the following competency: The practitioner uses knowledge of reading-writing-speaking connections to teach the skills and processes necessary for writing narrative, expressive, persuasive, informational, and descriptive texts, including text structures and mechanics such as grammar, usage, and spelling.

(7) Reading assessment, diagnosis and evaluation. This requirement includes the following competencies:

1. The practitioner uses knowledge of a variety of instruments, procedures, and practices that range from individual to group and from formal to informal to alternative for the identification of students' reading proficiencies and needs, for planning and revising instruction for all students, and for communicating the results of ongoing assessments to all stakeholders.

2. The practitioner demonstrates awareness of policies and procedures related to special programs.

(8) Adolescent or young adult nonfiction and fiction. This requirement includes the following competency: The practitioner uses knowledge of adolescent or young adult literature 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.

(9) Reading instructional strategies. This requirement includes the following competency: The practitioner uses knowledge of a range of research-based strategies and instructional technology for designing and delivering instruction across the curriculum, for grouping students, and for selecting materials appropriate for learners at various stages of reading and writing development and from varied cultural and linguistic backgrounds.

13.28(16) *Reading specialist.* K-12. The applicant must have met the requirements for the standard license and a teaching endorsement, and present evidence of at least one year 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 27 semester hours to include the following:

(1) Educational psychology/human growth and development.
(2) Educational measurement and evaluation.
(3) Foundations of reading.
(4) Diagnosis of reading problems.
(5) Remedial reading.
(6) Psychology of reading.
(7) Language learning and reading disabilities.
(8) Practicum in reading.
(9) Administration and supervision of reading programs at the elementary and secondary levels.

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) 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. General science. 5-12. Completion of 24 semester hours in science to include coursework in biological science, chemistry, and physics.

f. Physical science. 5-12. Completion of 24 semester hours in physical sciences to include coursework in physics, chemistry, and earth science.

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. 5-8. The holder of this endorsement must also hold the middle school endorsement listed under rule 282—13.27(272).

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

(2) 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.

i. All science II. 9-12.

(1) Required coursework.

1. Completion of one of the following endorsement areas listed under subrule 13.28(17): biological science 5-12 or chemistry 5-12 or earth science 5-12 or physics 5-12.

2. Completion of at least 12 hours in each of the other three endorsement areas.

(2) 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.

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. Program requirements.

(1) Degree—baccalaureate, and

(2) Completion of an approved human relations program, and

(3) Completion of the professional education core. See subrules 13.18(3) and 13.18(4).

c. 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.

d. Other. Individuals who were licensed in Iowa prior to October 1, 1988, and were allowed to teach English as a second language without completing the endorsement requirements must complete the endorsement requirements by July 1, 2012, in order to teach or continue to teach English as a second language. A waiver provision is available through the board of educational examiners for individuals who have been successfully teaching English as a second language.

13.28(21) *Elementary school teacher librarian.*

a. Authorization. The holder of this endorsement is authorized to serve as a teacher librarian in kindergarten and grades one through eight.

b. Program requirements.

(1) Degree—baccalaureate.

(2) Completion of an approved human relations program.

(3) Completion of the professional education core. See subrules 13.18(3) and 13.18(4).

c. Content—prior to September 1, 2012. The following requirements apply for endorsements issued prior to September 1, 2012. Completion of 24 semester hours in school library coursework to include the following:

(1) Knowledge of materials and literature in all formats for elementary children.

(2) Selection, utilization and evaluation of library resources and equipment.

(3) Design and production of instructional materials.

(4) Acquisition, cataloging and classification of library materials.

(5) Information literacy, reference services and networking.

(6) Planning, evaluation and administration of school library programs.

(7) Practicum in an elementary school media center/library.

d. Content—effective on and after September 1, 2012. The following requirements apply for endorsements issued on and after September 1, 2012. 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. Program requirements.

(1) Degree—baccalaureate.

(2) Completion of an approved human relations program.

(3) Completion of the professional education core. See subrules 13.18(3) and 13.18(4).

c. Content—prior to September 1, 2012. The following requirements apply for endorsements issued prior to September 1, 2012. Completion of 24 semester hours in school library coursework to include the following:

(1) Knowledge of materials and literature in all formats for adolescents.

(2) Selection, utilization and evaluation of library resources and equipment.

(3) Design and production of instructional materials.

(4) Acquisition, cataloging and classification of library materials.

(5) Information literacy, reference services and networking.

(6) Planning, evaluation and administration of school library programs.

(7) Practicum in a secondary school media center/library.

d. Content—effective on and after September 1, 2012. The following requirements apply for endorsements issued on and after September 1, 2012. 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—prior to September 1, 2012. The following requirements apply for endorsements issued prior to September 1, 2012. 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) Planning, evaluation and administration of school library programs.

(2) Curriculum development and teaching and learning strategies.

(3) Instructional development and communication theory.

(4) Selection, evaluation and utilization of library resources and equipment.

(5) Acquisition, cataloging and classification of library materials.

(6) Design and production of instructional materials.

(7) Methods for instruction and integration of information literacy skills into the school curriculum.

(8) Information literacy, reference services and networking.

(9) Knowledge of materials and literature in all formats for elementary children and adolescents.

(10) Reading, listening and viewing guidance.

(11) Utilization and application of computer technology.

(12) Practicum at both the elementary and secondary levels.

(13) Research in library and information science.

d. Content—effective on and after September 1, 2012. The following requirements apply for endorsements issued on and after September 1, 2012. 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.

c. Other. Individuals who were licensed in Iowa prior to August 31, 1995, and were allowed to teach talented and gifted classes without completing the endorsement requirements must complete the endorsement requirements by July 1, 2012, in order to teach or continue to teach talented and gifted classes. A waiver provision is provided through the board of educational examiners for individuals who have been successfully teaching students who are talented and gifted.

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. Program requirements.

(1) Degree—baccalaureate.

(2) Completion of an approved human relations program.

(3) Completion of the professional education core.

c. 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.

d. Other. Be the holder of or be eligible for one other teaching endorsement listed in rules 282—13.26(272) and 282—13.27(272) and this rule.

13.28(26) *Elementary counselor.*

a. Authorization. The holder of this endorsement has not completed the professional education core (subrule 13.18(4)) but is authorized to serve as a school guidance counselor in kindergarten and grades one through eight.

b. Program requirements.

(1) Master's degree from an accredited institution of higher education.

(2) Completion of an approved human relations component.

(3) Completion of an approved exceptional learner component.

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 counselor role to school personnel, parents, community, and students.

(8) School counseling skills.

1. Design, implement, and evaluate a comprehensive, developmental school guidance 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 counseling and guidance 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 classroom guidance and large group guidance lessons.

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 school counselor demonstrates competency in conducting classroom sessions with elementary and middle school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group counseling, developmental classroom guidance, and consultation.

13.28(27) *Secondary counselor.*

a. Authorization. The holder of this endorsement has not completed the professional education core (subrule 13.18(4)) but is authorized to serve as a school guidance counselor in grades five through twelve.

b. Program requirements.

(1) Master's degree from an accredited institution of higher education.

(2) Completion of an approved human relations component.

(3) Completion of an approved exceptional learner component.

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 counselor role to school personnel, parents, community, and students.

(8) School counseling skills.

1. Design, implement, and evaluate a comprehensive, developmental school guidance 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 counseling and guidance 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 classroom guidance and large group guidance lessons.
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 school counselor demonstrates competency in conducting classroom sessions with middle and secondary school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group work, developmental classroom guidance and consultation.

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. Program requirements.

(1) Degree—baccalaureate, and

(2) Completion of an approved human relations program, and

(3) Completion of the professional education core. See subrules 13.18(3) and 13.18(4).

c. 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.

d. 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.

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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. Receive verification from a state-approved and regionally accredited institution that the Iowa minimum requirements for the endorsement have been met.

(4) Option 4. 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 listed in rules 282—13.18(272) and 282—13.28(272), applicants for endorsements shall have completed a methods class appropriate for teaching the general subject area of the endorsement added.

(2) Practitioners who are adding an elementary or early childhood endorsement and have not student taught on the elementary or early childhood level shall complete a teaching practicum appropriate for teaching at the level of the new endorsement.

(3) Practitioners who are adding a secondary teaching endorsement and have not student taught on the secondary level shall complete a teaching practicum appropriate for teaching at the level of the new endorsement.

(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.

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]

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

13.30(1) *Issue date on original license.* A license is valid only from and after the date of issuance.

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.

These rules are intended to implement Iowa Code chapter 272.

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CHAPTER 15
SPECIAL EDUCATION SUPPORT PERSONNEL AUTHORIZATIONS

282—15.1(272) Authorizations requiring a license.

15.1(1) The following licenses are based on teaching endorsements.

a. Special education consultant.

b. Itinerant hospital services or home services teacher.

c. Special education media specialist.

d. Supervisor of special education—instructional.

e. Work experience coordinator.

15.1(2) The following licenses are based on school-centered preparation, but the sequence of coursework does not permit service as a teacher.

a. School psychologist.

b. Speech-language pathologist.

c. School audiologist.

d. School social worker.

e. Orientation and mobility specialist.

f. Supervisor of special education—support.

282—15.2(272) Special education consultant.

15.2(1) *Authorization.* The holder of this endorsement is authorized to serve as a special education consultant. The consultant provides ongoing assistance to instructional programs for pupils requiring special education. A consultant can serve programs with pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8) with the exception of consultants serving deaf or hard-of-hearing or visually disabled students. Applicants who desire to serve as consultants serving deaf or hard-of-hearing or visually disabled students must hold the respective special education instructional endorsement. The deaf or hard-of-hearing consultant endorsement or the visually disabled consultant endorsement allows the individual to serve students from birth to age 21.

15.2(2) *Program requirements.*

a. An applicant must hold a master's degree.

(1) Option 1: Master's in special education.

(2) Option 2: Master's in another area of education plus an endorsement in at least one special education instructional area under rule 282—14.2(272).

b. Content. The coursework is to be at least 8 graduate semester hours to include the following:

(1) Curriculum development design.

(2) Consultation process in special or regular education:

1. Examination, analysis, and application of a methodological model for consulting with teachers and other adults involved in the educational program.

2. Interpersonal relations, interaction patterns, interpersonal influence, and communication skills.

(3) Skills required for conducting a needs assessment, delivering staff in-service needs, and evaluating in-service sessions.

15.2(3) *Other.* An applicant must have four years of successful teaching experience, two of which must be in special education.

282—15.3(272) Itinerant hospital services or home services teacher.

15.3(1) *Authorization.* The holder of this endorsement is authorized to provide instructional services to those special education pupils hospitalized or homebound and unable to attend class.

15.3(2) *Program requirements.* An applicant must hold a baccalaureate degree.

15.3(3) *Other.*

a. An applicant must hold a teaching license. This authorization is restricted to the instructional grade level held:

(1) Prekindergarten-kindergarten.

(2) K-8.

(3) 5-12.

b. Personnel assigned to provide instructional services in psychiatric wards must have the endorsement to serve behavioral disordered students at the proper instructional grade level.

282—15.4(272) Special education media specialist.

15.4(1) *Authorization.* The holder of this endorsement is authorized to serve as a special education media specialist. This support personnel provides correlation of media services only for pupils requiring special education.

15.4(2) *Program requirements.* An applicant must hold a master's degree with emphasis in the specialized area of educational media.

15.4(3) *Other.* An applicant must hold one of the teaching endorsements for special education or one of the teaching endorsements outlined in rule 282—14.2(272).

282—15.5(272) Supervisor of special education—instructional.

15.5(1) *Authorization.* The holder of this endorsement is authorized to serve as a supervisor of special education instructional programs. Two endorsements are available within this category:

a. The early childhood—special education supervisor endorsement allows the individual to provide services to programs with pupils below the age of 7.

b. The supervisor of special education—instructional endorsement (K-12) allows the individual to provide services to programs with pupils from age 5 to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

15.5(2) *Program requirements.*

a. An applicant must hold a master's degree.

(1) Option 1: Master's in special education.

(2) Option 2: Master's in another area of education plus 30 graduate semester hours in special education (instructional). These hours may have been part of, or in addition to, the degree requirements.

b. An applicant must meet the requirements for or hold the consultant endorsement.

c. Content. The program shall include a minimum of 16 graduate semester hours to specifically include the following:

(1) Coursework requirements specified for special education consultant. Refer to rule 282—15.2(272).

(2) Current issues in special education administration including school law/special education law.

(3) School personnel administration.

(4) Program evaluation.

(5) Educational leadership.

(6) Administration and supervision of special education.

(7) Practicum: special education administration. NOTE: This requirement may be waived based on two years of experience as a special education administrator.

(8) Evaluator approval component.

15.5(3) *Other.*

a. An applicant must have two years of consultant/supervisor/coordinator/head teacher or equivalent experience in special education.

b. The supervisor for early childhood—special education would need to meet the requirements for that endorsement. The K-12 supervisor would need to meet the requirements for one special education teaching endorsement to include instructional grade levels K-8 and 5-12.

[**ARC 9073B**, IAB 9/8/10, effective 10/13/10]

282—15.6(272) Work experience coordinator.

15.6(1) *Authorization.* The holder of this endorsement is authorized to provide support service as a work experience coordinator to secondary school programs, grades 5-12 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

15.6(2) *Program requirements.*

a. An applicant must hold a baccalaureate degree.

b. Content. The coursework must include:

(1) A course in career-vocational programming for special education students (if not included in the program for 5-12 endorsement).

(2) A course in coordination of cooperative occupational education programs.

(3) A course in career-vocational assessment and guidance of the handicapped.

15.6(3) *Other.* An applicant must hold a special education endorsement—grades 5-12.

282—15.7(272) Other special education practitioner endorsements.

15.7(1) *School psychologist.* Rescinded IAB 7/29/09, effective 9/2/09.

15.7(2) *School psychologist one-year Class A license.* Rescinded IAB 7/29/09, effective 9/2/09.

15.7(3) *Speech-language pathologist.* Rescinded IAB 7/29/09, effective 9/2/09.

15.7(4) *School audiologist.* Rescinded IAB 7/29/09, effective 9/2/09.

15.7(5) *School social worker.* Rescinded IAB 7/29/09, effective 9/2/09.

15.7(6) *Orientation and mobility specialist.*

a. Authorization. The holder of this license is authorized to teach pupils with a visual impairment (see Iowa Code section 256B.2), including those pupils who are deaf-blind.

b. Provisional orientation and mobility license. The provisional license is valid for three years. An applicant must:

(1) Hold a baccalaureate or master's degree from an approved state and regionally accredited program in orientation and mobility or equivalent coursework.

(2) Have completed an approved human relations component.

(3) 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.

(4) 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.

(5) Have completed at least 350 hours of fieldwork and training under the supervision of the university program.

c. Standard orientation and mobility license. An applicant must:

(1) Complete the requirements set forth in paragraph 15.7(6)*"b."*

(2) Verify successful completion of a three-year probationary period.

d. Renewal of orientation and mobility license. An applicant must:

(1) Complete six units earned in any combination listed below.

1. One unit may be earned for each semester hour of graduate credit, completed through a regionally accredited institution, which leads toward the completion of a planned master's, specialist's, or doctor's degree program.

2. One unit may be earned for each semester hour of graduate or undergraduate credit, completed through a regionally accredited institution, which may not lead to a degree but which adds greater depth and breadth to present endorsements held.

3. One unit may be earned for each semester hour of credit, completed through a regionally accredited institution, which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.

4. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.

(2) Submit documentation of completion of the child and dependent adult abuse training approved by the state abuse education review panel. A waiver of this requirement may apply under the following conditions with appropriate documentation of any of the following:

1. A person is engaged in active duty in the military service of this state or of the United States.

2. The application of this requirement would impose an undue hardship on the person for whom the waiver is requested.

3. A person is practicing a licensed profession outside this state.

4. A person is otherwise subject to circumstances that would preclude the person from satisfying the approved child and dependent adult abuse training in this state.

e. Exception. An orientation and mobility specialist is not eligible for any administrator license in either general education or special education.

[**ARC 7986B**, IAB 7/29/09, effective 9/2/09; **ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—15.8(272) Supervisor of special education—support. Rescinded IAB 7/29/09, effective 9/2/09.

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CHAPTER 17
CAREER AND TECHNICAL ENDORSEMENTS AND LICENSES

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 16]

282—17.1(272) Requirements for secondary level (grades 7-12) license. The initial license with the appropriate endorsement will be issued if the requirements of rules 282—13.6(272) and 282—13.18(272) for initial licensing have been met.

17.1(1) *Secondary level career and technical endorsements.* The following are required for adding secondary level career and technical endorsements to an initial, standard, master educator, or permanent professional teaching license.

a. Agricultural sciences and agribusiness.

(1) Completion of 24 semester credit hours in agriculture and agriculture education to include:

1. Foundations of vocational and career education.
2. Planning and implementing courses and curriculum.
3. Methods and techniques of instruction to include evaluation of programs and students.
4. Coordination of cooperative education programs.
5. Coursework in each of the following areas and at least 3 semester credit hours in five of the following areas:

- Agribusiness systems;
- Power, structural, and technical systems;
- Plant systems;
- Animal systems;
- Natural resources systems;
- Environmental service systems; and
- Food products and processing systems.

(2) One thousand hours of work experience in one or more of the areas listed in 17.1(1)*"e."*

b. Marketing/distributive education. Completion of 24 semester hours in business to include a minimum of 6 semester hours each in marketing, management, and economics. Three thousand hours of recent, relevant work experience in occupations where the distribution of goods and services was the prime function. Coursework in foundations of career and technical education, in curriculum design oriented to marketing, and in the coordination of cooperative education programs.

c. Office education. Completion of 24 semester hours in business to include coursework in office management, business communications, word and data processing, and computer applications in business. Three thousand hours of recent, relevant work experience in an office-related occupation. Coursework in foundations of career and technical education, in curriculum design oriented to office education, and in the coordination of cooperative education programs.

d. Consumer and homemaking education. Completion of 24 semester hours in food and nutrition, consumer education, family living and parenthood education, child development, housing, home and resource management, and clothing and textiles. Four hundred hours of work experience in one or more homemaking or consumer-related occupations. Coursework in consumer and homemaking education to include methods and techniques of instruction, foundations of career and technical education, course and curriculum development, and evaluation of programs and students.

e. Career and technical home economics.

(1) Option 1. Completion of the requirements for consumer and homemaking education (see 17.1(1)*"d"*) and special preparation in the career and technical area or 400 hours of employment related specifically to the career and technical area.

(2) Option 2. Completion of a baccalaureate degree with a major in the career and technical area, coursework in methods and techniques of teaching, course and curriculum development, evaluation of programs and students, foundations of career and technical education, coordination of cooperative programs and a teaching practicum (supervised or assessment of other teaching experience), and 400 hours of employment related specifically to the career and technical area.

17.1(2) *Multioccupations.* Completion of any 7-12 endorsement, and in addition thereto, coursework in foundations of career and technical education, coordination of cooperative programs, and competency-based curriculum development. Four thousand hours of career and technical experience in two or more occupations. The multioccupations endorsement also authorizes the holder to supervise students in cooperative programs, school-to-work programs, and similar programs in which the student is placed in school-sponsored, on-the-job situations.

17.1(3) *Specialized secondary career and technical endorsement programs.* These are bachelor's degree programs which include specific preparation in career and technical teacher education.

a. Health occupations. Four thousand hours of health care-related career and technical experience within five years preceding application for licensure in the occupation to be taught. Program completion leading to registration, certification, or licensure in Iowa in the health specialty to be taught. Coursework in foundations of career and technical education, planning and implementing courses and curriculum, methods and techniques of instruction, and evaluation of programs and students.

b. Trade and industrial subjects. Demonstrated career and technical competence in an industrial, trade, or technical field by completion of a minimum of 4,000 hours of practical, hands-on experience in the area in which the endorsement is sought or written examination. Coursework in foundations of career and technical education, planning and implementing courses and curriculum, methods and techniques of instruction, and evaluation of programs and students.

[**ARC 8404B**, IAB 12/16/09, effective 1/20/10]

282—17.2(272) Requirements for the initial career and technical secondary license. This license is valid for five years. This license 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.

17.2(1) An applicant for this license must have completed 6,000 hours of recent and relevant career and technical experience in the teaching endorsement area sought. In those subjects, career and technical areas or endorsement areas which require state registration, certification or licensure, the applicant must hold the appropriate license, registration or certificate before the initial career and technical secondary license or the career and technical secondary license will be issued.

17.2(2) Applicants must commit to complete the following requirements within the term of this license. Holders of this license are expected to make annual progress at a minimum rate of one course per year to complete the studies.

a. A new teachers' workshop of a minimum of 30 clock hours and specified competencies, to be completed during the first year of license validity.

b. Competency development in the methods and techniques of teaching.

c. Competency development in course and curriculum development.

d. Competency development in the measurement and evaluation of programs and students.

e. Competency development in the history and philosophy (foundations) of career and technical education.

f. An approved human relations course as described in rule 282—13.22(272).

17.2(3) Individuals who believe that their previous professional experiences or formal education and preparation indicate mastery of competencies in the required study areas 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 will be forwarded with recommendations to the board of educational examiners. Board personnel will make final determination as to the competencies mastered and cite studies which yet need to be completed, if any.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—17.3(272) Requirements for the career and technical secondary license. This license is valid for five years.

17.3(1) Initial requirements. An applicant for this license must meet the requirements for the initial career and technical secondary license.

17.3(2) Renewal requirements for the career and technical secondary license. Six units are needed for renewal. These units may be earned in any combination of the units listed below.

a. One renewal unit may be earned for each semester hour of credit which advances an applicant toward the completion of a degree program.

b. One renewal unit may be earned for each semester hour of credit completed which may not lead to a degree but which adds greater technical depth/competence to the endorsement(s) held.

c. Renewal units may be earned upon the completion of staff development programs approved through guidelines established by the board of educational examiners or a technical update program approved by the board of educational examiners.

17.3(3) The applicant must complete an approved human relations component if the applicant has not previously done so.

17.3(4) An applicant who renews a license issued by the board of educational examiners must submit documentation of completion of the child and dependent adult abuse training approved by the state abuse education review panel. A waiver of this requirement may apply under the following conditions with appropriate documentation of any of the following:

a. A person is engaged in active duty in the military service of this state or of the United States.

b. The application of this requirement would impose an undue hardship on the person for whom the waiver is requested.

c. A person is practicing a licensed profession outside this state.

d. A person is otherwise subject to circumstances that would preclude the person from satisfying the approved child and dependent adult abuse training in this state.

282—17.4(272) Requirements for a Class D career and technical license. A two-year Class D career and technical license may be issued to an applicant who has not met all of the experience requirements for the initial career and technical license.

These rules are intended to implement Iowa Code chapter 272.

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CHAPTER 20
RENEWALS
[Prior to 1/14/09, see Educational Examiners Board[282] Ch 17]

282—20.1(272) General renewal information. This chapter contains renewal requirements for those individuals desiring to renew the initial, standard, master educator, professional administrator, area education agency administrator, or substitute license or a statement of professional recognition (SPR). Individuals desiring to renew a license issued under some other title are referred to 282—Chapters 22, 23, and 24.

282—20.2(272) Renewal application forms. Application forms for renewal may be obtained from the board of educational examiners' Web site at www.boee.iowa.gov or by contacting the office at (515)281-3245.

282—20.3(272) Renewal of licenses.

20.3(1) *Issue date.* A renewed license is valid only from and after the date of issuance.

20.3(2) *General renewal requirements.* A license may be renewed for applicants who fulfill the general requirements set out in subrules 20.3(3) through 20.3(5) and the license-specific requirements set out in this chapter under each license.

20.3(3) *Background check.* Every renewal applicant is required to submit a completed application form with the applicant's signature to facilitate a check of the sex offender registry information under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, and the dependent adult abuse records maintained under Iowa Code chapter 235B. The board may assess the applicant a fee no greater than the costs associated with obtaining and evaluating the background check.

20.3(4) *Child and dependent adult abuse training.* Every renewal applicant must submit documentation of completion of the child and dependent adult abuse training approved by the state abuse education review panel. A waiver of this requirement may apply under the following conditions with appropriate documentation of any of the following:

a. A person is engaged in active duty in the military service of this state or of the United States.

b. The application of this requirement would impose an undue hardship on the person for whom the waiver is requested.

c. A person is practicing a licensed profession outside this state.

d. A person is otherwise subject to circumstances that would preclude the person from satisfying the approved child and dependent adult abuse training in this state.

20.3(5) *Recency of units for renewal.* If a license is renewed on or before the date of expiration, the units for renewal are acceptable if earned during the term of the license. If a license is not renewed on the date of expiration, the units for renewal must have been completed within the five-year period immediately preceding the date of application for the renewal.

20.3(6) *Timely renewal.* A license may only be renewed less than one year before it expires.

[**ARC 9451B**, IAB 4/6/11, effective 5/11/11; **ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—20.4(272) Specific renewal requirements for the initial license. In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272). If a person meets all requirements for the standard license except for the options required in rule 282—13.7(272), paragraph "2," the initial license may be renewed upon written request. A second renewal may be granted if the holder of the initial license has not met the options required in rule 282—13.7(272), paragraph "2," and if the license holder can provide evidence of teaching employment which will be acceptable for the experience requirement. Following payment of the appropriate fee (see rule 282—12.2(272), paragraph "17"), a Class A license may be issued instead of the renewal of the initial license for another initial license if the applicant verifies one of the following:

1. The applicant is involved in the second year of the mentoring and induction program, but the license will expire before the second year of teaching is completed.

2. The applicant has taught for two years in a nonpublic school setting and needs one additional year of teaching to convert the initial license to the standard license.

282—20.5(272) Specific renewal requirements for the standard license.

20.5(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.5(2) Six units are needed for renewal. These units may be earned in any combination listed as follows:

a. One unit may be earned for each semester hour of graduate credit, completed from a regionally accredited institution, which leads toward the completion of a planned master's, specialist's, or doctor's degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit, completed from a regionally accredited institution, which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit, completed from a regionally accredited institution, which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.

e. Four units may be earned for successful completion of the National Board for Professional Teaching Standards certification. This certification may be used one time for either the standard or the master educator license.

f. One unit may be earned upon successful acquisition of three points from the following activities:

(1) Mentoring a full-semester student teacher (12 or more weeks) is worth two points.

(2) Mentoring a half-semester student teacher (less than 12 weeks) is worth one point.

(3) Mentoring a practicum student or practicum students (early field experience) equivalent to 60 contact hours (hours may be accrued over several semesters) is worth one point.

(4) Attending (from start to finish) a cooperating teachers' workshop in conjunction with mentoring a student teacher or practicum student is worth one point.

(5) Serving as a multiyear member of a teacher education program's advisory committee is worth one point.

282—20.6(272) Specific renewal requirements for a master educator license.

20.6(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.6(2) Four units are needed for renewal. These units may be earned in any combination listed below:

a. One unit may be earned for each semester hour of graduate credit, completed from a regionally accredited institution, which leads toward the completion of a planned master's, specialist's, or doctor's degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit, completed from a regionally accredited institution, which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit, completed from a regionally accredited institution, which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.

e. Four units may be earned upon successful completion of the National Board for Professional Teaching Standards certification. This certification may be used one time for either the standard or the master educator license.

f. One unit may be earned upon successful acquisition of three points from the following activities:

(1) Mentoring a full-semester student teacher (12 or more weeks) is worth two points.

(2) Mentoring a half-semester student teacher (less than 12 weeks) is worth one point.

(3) Mentoring a practicum student or practicum students (early field experience) equivalent to 60 contact hours (hours may be accrued over several semesters) is worth one point.

(4) Attending (from start to finish) a cooperating teachers' workshop in conjunction with mentoring a student teacher or practicum student is worth one point.

(5) Serving as a multiyear member of a teacher education program's advisory committee is worth one point.

282—20.7(272) Specific renewal requirements for a substitute license. In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272). An applicant for renewal of a substitute license shall meet one of the requirements listed below:

1. Verification of at least 30 days of substitute teaching during the term of the license or one year of teaching experience within the last five years completed during the term of a valid Iowa teaching license.

2. Completion of a local education agency or area education agency course approved through licensure renewal guidelines established by the board of educational examiners.

3. Completion of one semester hour of credit taken from a community college, college, or university.

[**ARC 7988B**, IAB 7/29/09, effective 9/2/09]

282—20.8(272) Specific renewal requirements for the initial administrator license. In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.8(1) *Requirements.* If an applicant meets all requirements for the professional administrator license except for the requirements in 282—subrule 18.4(1), the initial administrator license may be renewed upon written request. A second renewal may be granted if the holder of the initial administrator license has not met the requirements in 282—subrule 18.4(1) and if the license holder can provide evidence of employment as a PK-12 administrator, which meets the experience requirement.

20.8(2) *Extension.* Following payment of the appropriate fee (see 282—subrule 12.2(19)), an extension of the initial administrator license may be issued instead of the renewal of the initial administrator license, if the applicant verifies one of the following:

a. The applicant is involved in a mentoring and induction program, but the license will expire before the first year of administrative experience is completed.

b. The applicant has one year of administrative experience in a nonpublic school setting or in an out-of-state setting and needs one additional year of administrative experience to convert the initial license to the professional license.

282—20.9(272) Specific renewal requirements for an administrator license.

20.9(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.9(2) Four units are needed for renewal. These units may be earned in any combination listed below.

a. One unit may be earned for each semester hour of graduate credit, completed from a regionally accredited institution, which leads toward the completion of a planned specialist's or doctor's degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit, completed from a regionally accredited institution, which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit, completed from a regionally accredited institution, which may not lead to a degree but which leads to completion of requirements for an administrator endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.

20.9(3) Evaluator training. An applicant renewing an administrator license must submit documentation of completion of the evaluator training required in Iowa Code section 284.10. A waiver of the evaluator training may apply under the following conditions with appropriate documentation of any of the following:

a. The person is engaged in active duty in the military service of this state or of the United States.

b. The application of the evaluator training would impose an undue hardship on the person for whom the waiver is requested.

c. The person is practicing in a licensed profession outside this state.

282—20.10(272) Renewal requirements for a statement of professional recognition (SPR).

20.10(1) Renewal of the SPR.

a. The applicant must:

(1) Apply for renewal every five years.

(2) Maintain continual licensure with the board with which the applicant holds other licensure.

(3) Complete continuing education as required by the board with which the applicant holds other licensure.

b. The SPR shall be valid for five years.

c. The fee for issuance of the SPR certificate shall be the same as for a standard license as set forth in 282—Chapter 12. All fees are nonrefundable.

20.10(2) Each applicant renewing an SPR must provide documentation that all renewal requirements in subrules 20.3(1) through 20.3(4) have been met.

282—20.11(272) Audit of applications for license renewal. The board will randomly audit a minimum of 10 percent of the applications for renewal of the standard, master educator, and administrator licenses.

20.11(1) *Verification required.* If audited, the licensee must submit verification of compliance with renewal credit requirements. Licensees are required to keep transcripts of courses taken during the term of the license. Original transcripts and all other documents as required by 282—Chapter 20 must be submitted within 30 calendar days after the date of the audit. An extension of time may be granted on an individual basis.

20.11(2) *Results of audit.*

a. The board shall notify the licensee of satisfactory completion of the audit by issuing the license.

b. A licensee's failure to complete the audit satisfactorily or falsification of information shall be considered a violation of 282—Chapter 25, Code of Professional Conduct and Ethics, and the executive director may initiate a complaint against the licensee.

c. A licensee's failure to notify the board of a current mailing address will not absolve the licensee from the audit requirement; completion of an audit will be required prior to further license renewal.

282—20.12(272) Appeal procedure. Any teacher seeking a different level of license who is denied the license due to the evaluation or other requirements may appeal the decision. The appeal shall be made in writing to the executive director of the board of educational examiners who shall establish a date for the hearing within 20 days of receipt of written notice of appeal by giving five days' written notice to appellant unless a shorter time is mutually agreeable. The procedures for hearing followed by the board of educational examiners shall be applicable.

282—20.13(272) Licensure renewal programs.

20.13(1) *Application process.* These rules are to be followed in the preparation and submission of proposals for licensure renewal programs. The application materials must be returned to the board of educational examiners for review and approval. Once the application has been submitted, it will be reviewed, and the applicant agency will be notified of approval or nonapproval and any deficiencies.

20.13(2) *Application for licensure renewal program.*

a. The application shall contain evidence that the local board of directors (the boards of directors in consortium-based applications) has given formal approval to the development and implementation of the program and the allocation of program resources.

b. The application shall identify the criteria used in selecting faculty/instructors for the licensure renewal programs. These criteria shall include qualifications, experiences (relevant to the nature of the program), preparation and licensure status.

c. There must be evidence of a current survey using multiple data sources that includes, but is not limited to, district and building school improvement goals as well as staff needs and an explanation of procedures used to derive such needs; this documentation must be furnished as a part of the application for a licensure renewal program.

d. Programs developed by eligible agencies shall be based on evidence gathered from the survey referenced in paragraph *"c"* above.

e. Program objectives must be derived from identified educational needs in the district or districts or special groups to be served; these objectives shall be developed by the eligible agency seeking approval under licensure renewal programs.

f. Each application must include procedures for program evaluation; this evaluation must include faculty/instructor as well as course/activity evaluation. Program and course/activity evaluation shall include, but not be limited to, participant perceptions.

g. Evaluation. The evaluation shall include participant perception and, whenever possible, observation data collection techniques and analyses are required for each approved licensure renewal program.

20.13(3) *Eligible agencies/institutions.*

a. Teacher renewal.

(1) Area education agencies, local education agencies, individually or in consortium arrangements.

(2) Approved nonpublic districts, individually or in consortium arrangements.

(3) Iowa educational professional organizations.

(4) Iowa colleges and universities approved for teacher education.

b. Administrator renewal.

(1) Area education agencies, local education agencies, individually or in consortium arrangements.

(2) Approved nonpublic districts, individually or in consortium arrangements.

(3) Iowa educational professional organizations.

(4) Iowa colleges and universities approved for teacher education.

20.13(4) *Authority.* The acceptance of licensure renewal credit is provided in rules 282—20.5(272), 282—20.6(272), and 282—20.9(272).

20.13(5) *Licensure renewal courses.*

a. Licensure renewal courses are planned experiences, activities, and studies designed to develop skills, techniques, knowledge, and understanding of educational research and best practice and to model best practices in professional and organizational development. These courses support school improvement processes and practices and provide for the development of leadership in education. Approved courses and programs must be designed to follow the terms of the renewal requirements set forth for teacher and administrator license renewal in rules 282—20.5(272), 282—20.6(272), and 282—20.9(272). The following indicators of quality will be used in evaluating the approved license renewal programs:

(1) The courses address specific student, teacher, and school needs evidenced in local school improvement plans; or

(2) The courses assist teachers in improving student learning; or

(3) The courses assist teachers in improving teaching evidenced through the adoption or application of practices, strategies, and information.

b. Approved teacher licensure renewal programs must offer and conduct a minimum of ten different courses for teachers during the calendar year, and approved administrator licensure renewal programs must conduct a minimum of five different courses for administrators during the calendar year.

c. A minimum of 15 scheduled clock hours of contact with the instructor, study groups or action research teams equal one renewal unit. Only whole units may be submitted to the board of educational examiners for license renewal.

d. Only renewal units offered through board of educational examiners-approved licensure renewal programs will be accepted for license renewal.

20.13(6) *Licensure renewal advisory committee.* Licensure renewal programs must be developed with the assistance of a licensure renewal advisory committee.

a. Membership of the advisory committee. Once the advisory committee is established, matters pertaining to the term of membership shall be spelled out through established procedures. The advisory committee shall consist of no fewer than five members. The licensure renewal coordinator shall forward the current updated list of licensure renewal advisory committee members to the board of educational examiners upon request.

(1) The licensure renewal advisory committee shall include the following persons for teacher/administrator renewal programs:

1. Elementary and secondary classroom teachers.
2. Local administrators: elementary or secondary principals, curriculum director or superintendent.
3. Higher education representative from a college or university offering an approved teacher education program.
4. Other categories may also be appointed: community college teaching faculty, students, area education agency staff members, school board members, members of educational professional organizations, business/industry representatives, community representatives, representatives of substitute teachers.

(2) The make-up of the membership should reflect the ratio of teachers to administrators within an agency or organization offering an approved licensure renewal program. The membership should reflect the general population by a balance of gender and race and shall be balanced between urban and rural districts.

(3) The licensure renewal coordinator shall be a nonvoting advisory committee member.

(4) Disputes about the appropriate composition of the membership of the licensure renewal advisory committee shall be resolved through local committee action.

b. Responsibilities of licensure renewal advisory committee. The licensure renewal advisory committee shall be involved in:

(1) The ongoing area education agency, local district, or other agency staff development needs assessment.

(2) The design and development of an original application for a license renewal program.

(3) The development of criteria for the selection of course instructors; and these criteria shall include, but not be limited to, academic preparation, experience and certification status.

(4) The annual evaluation of licensure renewal programs.

20.13(7) *Licensure renewal coordinator.*

a. Each agency or organization offering an approved licensure renewal program shall identify a licensed (elementary or secondary) professional staff member who shall be designated as coordinator for the program. This function must be assigned; no application will be approved unless this function has been assigned.

b. Responsibilities of licensure renewal coordinators:

(1) File all reports as requested by the board of educational examiners.

(2) Serve as a contact person for the board of educational examiners.

(3) Be responsible for the development of licensure renewal programs which address the professional growth concerns of the clientele.

(4) Be responsible for the approval of all courses or units offered for licensure renewal.

(5) Maintain records of approved courses as conducted and of the names of the qualifying participants.

(6) Maintain a list of all course offerings and approved instructors and forward the list to the board of educational examiners.

(7) Provide a record of credit for each participant and maintain a cumulative record of credits earned for each participant for a minimum of ten years.

(8) Be responsible for informing participants of the reporting procedures for renewal credits/units earned.

20.13(8) *Organization and administration.*

a. Local school districts are encouraged to work cooperatively with their respective area education agency in assessing needs and designing and conducting courses.

b. The board of educational examiners reserves the right to evaluate any course, to require submission of evaluation data and to conduct sufficient on-site evaluation to ensure high quality of licensure renewal programs.

c. Agencies or institutions developing new programs shall submit a letter of intent prior to the submission of an application. The application must be filed at least three months prior to the initiation of any planned licensure renewal program.

d. Once a program is approved, the coordinator shall approve all course offerings for licensure renewal units.

e. Initial approval may be for one to three years. Continuing approval may be granted for five-year terms. Continuing approval may involve board of educational examiners sponsored team visits.

f. Records retention. Each approved staff development agency/institution shall retain program descriptions, course activities, documentation of the qualifications of delivery personnel, evaluation reports, and completed renewal units for a period of ten years. This information shall be kept on file in the offices of the area education agency licensure renewal coordinators and shall be made available to the board of educational examiners upon request.

g. Monitoring and evaluation. Each approved licensure renewal program will be monitored by the board of educational examiners to determine the extent to which the program meets/continues to meet program standards and is moving toward the attainment of program objectives. This will include an annual report which shall include an annotated description of the courses provided, evidence of the collaborative efforts used in developing the courses, evidence of the intended results of the courses, and the data for demonstrating progress toward the intended results.

These rules are intended to implement Iowa Code chapter 272.

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CHAPTER 25
CODE OF PROFESSIONAL CONDUCT AND ETHICS

282—25.1(272) Scope of standards. This code of professional conduct and ethics constitutes mandatory minimum standards of practice for all licensed practitioners as defined in Iowa Code chapter 272. The adherence to certain professional and ethical standards is essential to maintaining the integrity of the education profession.

282—25.2(272) Definitions. Except where otherwise specifically defined by law:

"Administrative and supervisory personnel" means any licensed employee such as superintendent, associate superintendent, assistant superintendent, principal, associate principal, assistant principal, or other person who does not have as a primary duty the instruction of pupils in the schools.

"Board" means the Iowa board of educational examiners.

"Discipline" means the process of sanctioning a license, certificate or authorization issued by the board.

"Ethics" means a set of principles governing the conduct of all persons governed by these rules.

"Fraud" means knowingly providing false information or representations on an application for licensure or employment, or knowingly providing false information or representations made in connection with the discharge of duties.

"License" means any license, certificate, or authorization granted by the board.

"Licensee" means any person holding a license, certificate, or authorization granted by the board.

"Practitioner" means an administrator, teacher, or other licensed professional, including an individual who holds a statement of professional recognition, who provides educational assistance to students.

"Responsibility" means a duty for which a person is accountable by virtue of licensure.

"Right" means a power, privilege, or immunity secured to a person by law.

"Student" means a person, regardless of age, enrolled in a prekindergarten through grade 12 school, who is receiving direct or indirect assistance from a person licensed by the board.

"Teacher" means any person engaged in the instructional program for prekindergarten through grade 12 children, including a person engaged in teaching, administration, and supervision, and who is required by law to be licensed for the position held.

[**ARC 7979B**, IAB 7/29/09, effective 9/2/09]

282—25.3(272) Standards of professional conduct and ethics. Licensees are required to abide by all federal, state, and local laws applicable to the fulfillment of professional obligations. Violation of federal, state, or local laws in the fulfillment of professional obligations constitutes unprofessional and unethical conduct which can result in disciplinary action by the board. In addition, it is hereby deemed unprofessional and unethical for any licensee to violate any of the following standards of professional conduct and ethics:

25.3(1) *Standard I—conviction of crimes, sexual or other immoral conduct with or toward a student, and child and dependent adult abuse.* Violation of this standard includes:

a. Fraud. Fraud means the same as defined in rule 282—25.2(272).

b. Criminal convictions. The commission of or conviction for a criminal offense as defined by Iowa law provided that the offense is relevant to or affects teaching or administrative performance.

(1) Disqualifying criminal convictions. The board shall deny an application for licensure and shall revoke a previously issued license if the applicant or licensee has, on or after July 1, 2002, been convicted of, has pled guilty to, or has been found guilty of the following criminal offenses, regardless of whether the judgment of conviction or sentence was deferred:

1. Any of the following forcible felonies included in Iowa Code section 702.11: child endangerment, assault, murder, sexual abuse, or kidnapping;

2. Any of the following criminal sexual offenses, as provided in Iowa Code chapter 709, involving a child:

- First-, second- or third-degree sexual abuse committed on or with a person who is under the age of 18;
- Lascivious acts with a child;
- Assault with intent to commit sexual abuse;
- Indecent contact with a child;
- Sexual exploitation by a counselor;
- Lascivious conduct with a minor;
- Sexual exploitation by a school employee;
- Enticing a minor under Iowa Code section 710.10; or
- Human trafficking under Iowa Code section 710A.2;

3. Incest involving a child as prohibited by Iowa Code section 726.2;

4. Dissemination and exhibition of obscene material to minors as prohibited by Iowa Code section 728.2;

5. Telephone dissemination of obscene material to minors as prohibited by Iowa Code section 728.15;

6. Any offense specified in the laws of another jurisdiction, or any offense that may be prosecuted in a federal, military, or foreign court, that is comparable to an offense listed in subparagraph 25.3(1)*"b"*(1); or

7. Any offense under prior laws of this state or another jurisdiction, or any offense under prior law that was prosecuted in a federal, military, or foreign court, that is comparable to an offense listed in subparagraph 25.3(1)*"b"*(1).

(2) Other criminal convictions and founded child abuse. In determining whether a person should be denied a license or whether a licensee should be disciplined based upon any other criminal conviction, including a conviction for an offense listed in 25.3(1)*"b"*(1) which occurred before July 1, 2002, or a founded report of abuse of a child, the board shall consider:

1. The nature and seriousness of the crime or founded abuse in relation to the position sought;

2. The time elapsed since the crime or founded abuse was committed;

3. The degree of rehabilitation which has taken place since the crime or founded abuse was committed;

4. The likelihood that the person will commit the same crime or abuse again;

5. The number of criminal convictions or founded abuses committed; and

6. Such additional factors as may in a particular case demonstrate mitigating circumstances or heightened risk to public safety.

c. Sexual involvement or indecent contact with a student. Sexual involvement includes, but is not limited to, the following acts, whether consensual or nonconsensual: fondling or touching the inner thigh, groin, buttocks, anus or breasts of a student; permitting or causing to fondle or touch the practitioner's inner thigh, groin, buttocks, anus, or breasts; or the commission of any sex act as defined in Iowa Code section 702.17.

d. Sexual exploitation of a minor. The commission of or any conviction for an offense prohibited by Iowa Code section 728.12, Iowa Code chapter 709 or 18 U.S.C. Section 2252A(a)(5)(B).

e. Student abuse. Licensees shall maintain professional relationships with all students, both inside and outside the classroom. The following acts or behavior constitutes unethical conduct without regard to the existence of a criminal charge or conviction:

(1) Committing any act of physical abuse of a student;

(2) Committing any act of dependent adult abuse on a dependent adult student;

(3) Committing or soliciting any sexual or otherwise indecent act with a student or any minor;

(4) Soliciting, encouraging, or consummating a romantic or otherwise inappropriate relationship with a student;

(5) Furnishing alcohol or illegal or unauthorized drugs or drug paraphernalia to any student or knowingly allowing a student to consume alcohol or illegal or unauthorized drugs in the presence of the licensee; or

(6) Failing to report any suspected act of child or dependent adult abuse as required by state law.

25.3(2) *Standard II—alcohol or drug abuse.* Violation of this standard includes:

a. Being on school premises or at a school-sponsored activity involving students while under the influence of, possessing, using, or consuming illegal or unauthorized drugs or abusing legal drugs.

b. Being on school premises or at a school-sponsored activity involving students while under the influence of, possessing, using, or consuming alcohol.

25.3(3) *Standard III—misrepresentation, falsification of information.* Violation of this standard includes:

a. Falsifying or deliberately misrepresenting or omitting material information regarding professional qualifications, criminal history, college credit, staff development credit, degrees, academic award, or employment history when applying for employment or licensure.

b. Falsifying or deliberately misrepresenting or omitting material information regarding compliance reports submitted to federal, state, and other governmental agencies.

c. Falsifying or deliberately misrepresenting or omitting material information submitted in the course of an official inquiry or investigation.

d. Falsifying any records or information submitted to the board in compliance with the license renewal requirements imposed under 282—Chapter 20.

e. Falsifying or deliberately misrepresenting or omitting material information regarding the evaluation of students or personnel, including improper administration of any standardized tests, including, but not limited to, changing test answers, providing test answers, copying or teaching identified test items, or using inappropriate accommodations or modifications for such tests.

25.3(4) *Standard IV—misuse of public funds and property.* Violation of this standard includes:

a. Failing to account properly for funds collected that were entrusted to the practitioner in an educational context.

b. Converting public property or funds to the personal use of the practitioner.

c. Submitting fraudulent requests for reimbursement of expenses or for pay.

d. Combining public or school-related funds with personal funds.

e. Failing to use time or funds granted for the purpose for which they were intended.

25.3(5) *Standard V—violations of contractual obligations.*

a. Violation of this standard includes:

(1) Signing a written professional employment contract while under contract with another school, school district, or area education agency.

(2) Asking a practitioner to sign a written professional employment contract before the practitioner has been unconditionally released from a current contract. An administrator shall make a good faith effort to determine whether the practitioner has been released from the current contract.

(3) Abandoning a written professional employment contract without prior unconditional release by the employer.

(4) As an employer, executing a written professional employment contract with a practitioner, which requires the performance of duties that the practitioner is not legally qualified to perform.

(5) As a practitioner, executing a written professional employment contract, which requires the performance of duties that the practitioner is not legally qualified to perform.

b. In addressing complaints based upon contractual obligations, the board shall consider factors beyond the practitioner's control. For purposes of enforcement of this standard, a practitioner will not be found to have abandoned an existing contract if:

(1) The practitioner obtained a release from the employing board before discontinuing services under the contract; or

(2) The practitioner provided notice to the employing board no later than the latest of the following dates:

1. The practitioner's last work day of the school year;
2. The date set for return of the contract as specified in statute; or
3. June 30.

25.3(6) *Standard VI—unethical practice toward other members of the profession, parents, students, and the community.* Violation of this standard includes:

a. Denying the student, without just cause, access to varying points of view.

b. Deliberately suppressing or distorting subject matter for which the educator bears responsibility.

c. Failing to make reasonable effort to protect the health and safety of the student or creating conditions harmful to student learning.

d. Conducting professional business in such a way that the practitioner repeatedly exposes students or other practitioners to unnecessary embarrassment or disparagement.

e. Engaging in any act of illegal discrimination, or otherwise denying a student or practitioner participation in the benefits of any program on the grounds of race, color, religion, age, sex, sexual orientation, gender identity, disability, marital status, or national origin.

f. Soliciting students or parents of students to purchase equipment, supplies, or services from the practitioner for the practitioner's personal advantage.

g. Accepting gifts from vendors or potential vendors where there may be the appearance of or an actual conflict of interest.

h. Intentionally disclosing confidential information including, but not limited to, unauthorized sharing of information concerning student academic or disciplinary records, health and medical information, assessment or testing results, or family income. Licensees shall comply with state and federal laws and local school board policies relating to the confidentiality of student records, unless disclosure is required or permitted by law.

i. Refusing to participate in a professional inquiry when requested by the board.

j. Aiding, assisting, or abetting an unlicensed person in the completion of acts for which licensure is required.

k. Failing to self-report to the board within 60 days any founded child abuse report, or any conviction for a criminal offense listed in 25.3(1)*"b"*(1) which requires revocation of the practitioner's license.

l. Delegating tasks to unqualified personnel.

m. Failing to comply with federal, state, and local laws applicable to the fulfillment of professional obligations.

n. Allowing another person to use one's practitioner license for any purpose.

o. Performing services beyond the authorized scope of practice for which the individual is licensed or prepared or performing services without holding a valid license.

p. Falsifying, forging, or altering a license issued by the board.

q. Failure of the practitioner holding a contract under Iowa Code section 279.13 to disclose to the school official responsible for determining assignments a teaching assignment for which the practitioner is not properly licensed.

r. Failure of a school official responsible for assigning licensed practitioners holding contracts under Iowa Code section 279.13 to adjust an assignment if the practitioner discloses to the official that the practitioner is not properly licensed for an assignment.

25.3(7) *Standard VII—compliance with state law governing obligations to state or local governments, student loan obligations, and child support obligations.* Violation of this standard includes:

a. Failing to comply with 282—Chapter 8 concerning payment of debts to state or local governments.

b. Failing to comply with 282—Chapter 9 concerning repayment of student loans.

c. Failing to comply with 282—Chapter 10 concerning child support obligations.

25.3(8) *Standard VIII—incompetence.* Violation of this standard includes, but is not limited to:

a. Willfully or repeatedly departing from or failing to conform to the minimum standards of acceptable and prevailing educational practice in the state of Iowa.

b. Willfully or repeatedly failing to practice with reasonable skill and safety.

[**ARC 8136B**, IAB 9/9/09, effective 10/14/09; **ARC 8137B**, IAB 9/9/09, effective 10/14/09; **ARC 9208B**, IAB 11/3/10, effective 12/8/10; **ARC 0025C**, IAB 3/7/12, effective 4/11/12; **ARC 0026C**, IAB 3/7/12, effective 4/11/12]

These rules are intended to implement Iowa Code section 272.2(1)*"a."*

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CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)*"e"*(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	$50.57 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/11.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

Provider category	Basis of reimbursement	Upper limit
		3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers effective 7/1/11: Provider's rate in effect 11/30/09. If no 11/30/09 rate: Veterans Administration contract rate or $22.12 per half-day, $44.03 per full day, or $66.03 per extended day if no Veterans Administration contract. For intellectual disability waiver: County contract rate or, effective 7/1/11 in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, $29.47 per half-day, $58.83 per full day, or $75.00 per extended day.
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Initial one-time fee: $49.53. Ongoing monthly fee: $38.52.
Portable locator system	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: One equipment purchase: $307.69. Initial one-time fee: $49.53. Ongoing monthly fee: $38.52.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09. For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $19.81 per hour.

Provider category	Basis of reimbursement	Upper limit
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $82.92 per visit. For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $82.92 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed $296.94 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $33.75 per hour not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed the facility's daily Medicaid rate.
Camps	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with mental retardation	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $7.71 per half hour.

Provider category	Basis of reimbursement	Upper limit
8. Home-delivered meals	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $7.71 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver: $1,010 lifetime maximum. For intellectual disability waiver: $5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6,060 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: $8.25 per unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/11: $110.05 per unit.
14. Senior companion	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: $6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $20.20 per hour not to exceed $116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $1,117 per calendar month. When prorated per day for a partial month, $36.71 per day.
Individual	Fee agreed upon by member and provider	Effective July 1, 2010, $13.47 per hour not to exceed $78.56 per day.
16. Counseling		
Individual:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $10.79 per unit.

Provider category	Basis of reimbursement	Upper limit
Group:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $43.14 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: $34.98 per hour, $78.88 per day not to exceed the maximum daily ICF/MR rate.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: $34.98 per hour. Maximum of 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: $34.98 per hour for all activities other than personal care and services in an enclave setting. $19.81 per hour for personal care. $6.19 per hour for services in an enclave setting. $2,883.71 per month for total service. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	$6,060 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $43.14 per hour.

Provider category	Basis of reimbursement	Upper limit
23. Prevocational services	Fee schedule	For the brain injury waiver effective 7/1/11: $48.22 per day, $24.11 per half-day, or $13.21 per hour. For the intellectual disability waiver effective 7/1/11: County contract rate or, in absence of a contract rate, $48.22 per day, $24.11 per half-day, or $13.21 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Child development home or center	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour.
Supported community living provider	Retrospectively limited prospective rate	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $34.98 per hour, not to exceed the maximum ICF/MR rate per day.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: The maximum ICF/MR rate per day.
26. Day habilitation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.21 per hour, $32.15 per half-day, or $64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $34.98 per hour.
29. In-home family therapy	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $93.63 per hour.
30. Financial management services	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $65.65 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $15.15 per hour.

Provider category	Basis of reimbursement	Upper limit
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.70 per hour or $105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.21 per hour, $32.15 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 11/30/09 less 5%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.

Provider category	Basis of reimbursement	Upper limit
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 11/30/09 less 5%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"2" and (2)"2" is 96% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 110% of the patient-day-weighted median.

Provider category	Basis of reimbursement	Upper limit
	The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.

Provider category	Basis of reimbursement	Upper limit
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	$6.20 dispensing fee effective 8/1/11. (See 79.1(8)*"a," "b,"* and *"e."*)
Psychiatric medical institutions for children 1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Effective 8/1/11: Fee schedule in effect 11/30/09.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.*

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate

exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)*"y"*(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients

under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2008 and every three years thereafter.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization.

The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical

rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing

implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)*"y"*(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph *"y."*

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph 79.1(5)*"y."* Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)*"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph *"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals

certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)*"i"* if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is $26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable,

and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $14,415,396. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard

deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,890,959. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5)*"u"* or 79.1(5)*"v"* cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. $9,900,000.

(2) One-twelfth of the $9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the $9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code	Explanation
Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory

procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Payment adjustment for services rendered in facility settings. When a service is rendered in a facility setting, the fee schedule amount paid to physicians based on paragraph 79.1(7)*"a"* shall be adjusted by a percentage differential that is equal to the percentage difference between the Medicare nonfacility and facility fee schedule amounts for Iowa. For the purpose of this provision, a "facility" place of service (POS) is defined as any of the following:

(1) Hospital inpatient unit (POS 21).
(2) Hospital outpatient unit (POS 22).
(3) Hospital emergency room (POS 23).
(4) Ambulatory surgical center (POS 24).
(5) Skilled nursing facility (POS 31).
(6) Inpatient psychiatric facility (POS 51).
(7) Community mental health center (POS 53).
(8) Comprehensive inpatient rehabilitation (POS 61).

79.1(8) *Drugs.* The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g"*; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph *"g."*

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph *"g."*

(4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g"*; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. No payment shall be made for sales tax.

d. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"a"* except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

g. For services rendered on or after August 1, 2011, the professional dispensing fee is $6.20 or the pharmacy's usual and customary fee, whichever is lower.

h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8)*"a"*(3) and 79.1(8)*"c"* and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) *HCBS consumer choices financial management.*

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)*"b,"*78.37(16)*"b,"*78.38(9)*"b,"*78.41(15)*"b,"*78.43(15)*"b,"* or 78.46(6)*"b."*

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to $10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than $25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is $25.01 to $50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is $50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay $1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay $2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay $3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay $1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a $3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)*"k."* This $3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed $1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 102.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 102.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over

30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular

OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." ● In all other circumstances, payment is made through a separate APC payment.

Q2	T-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)*"r."* If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)*"v."*

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;

2. Recompute Medicaid payments due based on the recalculated Medicaid rates;

3. Recoup any previous overpayments; and

4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members not participating in the MediPASS program who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993.

Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.
2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.
3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. $9,900,000.

(2) One-twelfth of the $9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the $9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall

request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph *"b"* and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph *"b."* The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1). The unit

of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.
2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed $1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24)*"b,"* the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the

amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled int he Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) *Grounds for sanctioning providers.* Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider's peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

79.2(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

d. Suspension or withholding of payments to provider.

e. Referral to peer review.

f. Prior authorization of services.

g. One hundred percent review of the provider's claims prior to payment.

h. Referral to the state licensing board for investigation.

i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

j. Providers with a total Medicaid credit balance of more than $500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over $500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) *Imposition and extent of sanction.*

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

(1) Seriousness of the offense.
(2) Extent of violations.
(3) History of prior violations.
(4) Prior imposition of sanctions.
(5) Prior provision of provider education.
(6) Provider willingness to obey program rules.
(7) Whether a lesser sanction will be sufficient to remedy the problem.
(8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5)*"c"* are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

a. The nature of the discrepancies or violations,
b. The known dollar value of the discrepancies or violations,
c. The method of computing the dollar value,
d. Notification of further actions to be taken or sanctions to be imposed by the department, and
e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a

final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

This rule is intended to implement Iowa Code section 249A.4.

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)*"d."* The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.

12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.

2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.

3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.

4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"e,"* 441—paragraph 77.39(14)*"d,"* or 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).

5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Any supplies dispensed as part of the service.

7. The first and last name and professional credentials, if any, of the person providing the service.

8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2)*"b."*)

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.

2. Nursing facility physician order.

3. Telephone order.

4. Pharmacy notes.

5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.

2. Anesthesia notes and records.

3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.

2. Certifying physician statement.

3. Prescription or order form.

(5) Certified registered nurse anesthetist services:
1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.
(6) Other advanced registered nurse practitioner services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
(7) Optometrist and optician services:
1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.
(8) Psychologist services:
1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.
(9) Clinic services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.
(10) Services provided by rural health clinics or federally qualified health centers:
1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.
(11) Services provided by community mental health centers:
1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.
4. Service or office notes or narratives.
5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.
(12) Screening center services:
1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.
(13) Family planning services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Immunization records.
5. Consent forms.
6. Prescriptions.
7. Medication administration records.
(14) Maternal health center services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Form 470-2942, Prenatal Risk Assessment.

(15) Birthing center services:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
2. Physician orders.
3. Consent forms.
4. Anesthesia records.
5. Pathology reports.
6. Laboratory and X-ray reports.

(17) Hospital services:

1. Physician orders.
2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.

(18) State mental hospital services:

1. Service referral documentation.
2. Resident assessment and initial evaluation.
3. Individual comprehensive treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:

1. Physician orders.
2. Progress or status notes.
3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Form 470-0042, Case Activity Report.

(20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.

(21) Services provided by psychiatric medical institutions for children:

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.

4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(22) Hospice services:

1. Physician certifications for hospice care.
2. Form 470-2618, Election of Medicaid Hospice Benefit.
3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:

1. Physician orders.
2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.

(24) Home- and community-based habilitation services:

1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.

(25) Behavioral health intervention:

1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.

(26) Services provided by area education agencies and local education agencies:

1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:

1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician orders or medical orders.

(28) Services provided by independent laboratories:

1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:

1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:

1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.

(31) Medical supplies:

1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.

4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:

1. Service notes or narratives.
2. Prescriptions.
3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:

1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
2. Notice of decision for service authorization.
3. Service notes or narratives.
4. Social history.
5. Comprehensive service plan.
6. Reassessment of member needs.
7. Incident reports in accordance with 441—subrule 24.4(5).

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.

(36) Physical therapist services:

1. Physician order for physical therapy.
2. Initial physical therapy certification, recertifications, and treatment plans.
3. Treatment notes and forms.
4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.
2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
2. Documentation of hearing aid evaluation and selection (Form 470-0828).
3. Waiver of informed consent.
4. Prior authorization documentation.
5. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) *Maintenance requirement.* The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) *Availability.* Rescinded IAB 1/30/08, effective 4/1/08.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 8262B**, IAB 11/4/09, effective 12/9/09; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11]

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services
Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
Reviewer Name & Phone Number: _____
Provider Name: _____
Provider Number: _____
Provider Type: _____

Please sign this form and return it with the information requested.
Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.
Please send copies. Do not send original records.
If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number

470-4479 (4/08)

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) *Membership.* The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2and 3.

79.7(3) *Expenses, staff support, and technical assistance.* Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) *Meetings.* The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) *Procedures.*

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) *Duties.*

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[**ARC 8263B**, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

This rule is intended to implement Iowa Code section 249A.4.

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

d. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) *State elections.* In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate whether or not an eligible professional is "hospital-based" for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010, eligible providers may elect to use either:

(1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or

(2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the hospital fiscal year.

79.16(2) *Eligible providers.* To be deemed an "eligible provider" for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children's hospital, defined as a separately certified children's hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional's patient volume covered by Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.
2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) *Application and agreement.* Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the EHR incentive payment program section of the Iowa

Medicaid portal access (IMPA) Web site at https://secureapp.dhs.state.ia.us/impa/. The applicant shall use the Web site to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and

(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, the eligible provider must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) *Payment.* The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

a. Provider eligibility determination.

b. Incentive payments.

c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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◊ Two or more ARCs

1 Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

3 Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

4 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.

5 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**.

6 Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

7 July 1, 2009, effective date of amendments to 79.1(1)*"d,"* 79.1(2), and 79.1(24)*"a"*(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS

PREAMBLE

Inpatient psychiatric services are provided in three types of psychiatric facilities in addition to general hospitals with psychiatric units: acute care psychiatric hospitals, psychiatric medical institutions for children, and nursing facilities for the mentally ill. Except for services in the state mental health institutes, Medicaid covers only persons under the age of 21 and persons aged 65 and older in acute care psychiatric hospitals. Medicaid covers only persons under the age of 21 in psychiatric medical institutions for children, and only persons aged 65 and older in nursing facilities for the mentally ill. These rules establish conditions of participation for providers, record-keeping requirements, reimbursement methodologies, and client eligibility requirements.

DIVISION I
PSYCHIATRIC HOSPITALS

441—85.1(249A) Acute care in psychiatric hospitals. These rules do not apply to general hospitals with psychiatric units.

85.1(1) *Psychiatric hospitals serving persons aged 21 and older.* A psychiatric hospital serving persons aged 21 and older shall meet the federal criteria for an institution for mental disease and shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B). An out-of-state facility shall be licensed as a psychiatric hospital, shall meet the federal criteria for an institution for mental disease, and shall be certified to participate in the Medicare program. An institution is an institution for mental disease only if its overall character is that of a facility established and maintained primarily for the care and treatment of persons with mental diseases. The following guidelines are used by the department in evaluating the overall character of a facility. These guidelines are all useful in identifying institutions for mental disease; however, no single guideline is necessarily determinative in any given case.

a. The facility:

(1) Is licensed as a psychiatric facility for the care and treatment of persons with mental diseases.

(2) Advertises or holds itself out as a facility for the care and treatment of persons with mental diseases.

(3) Is accredited as a psychiatric facility by the Joint Commission on the Accreditation of Health Care Organizations or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals.

(4) Specializes in providing psychiatric or psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric or psychological training or that a large proportion of the patients are receiving psychopharmacological drugs.

(5) Is under the jurisdiction of the division of behavioral, developmental, and protective services for families, adults, and children of the department.

b. More than 50 percent of all the patients in the facility have mental diseases which require inpatient treatment according to the patient's medical records.

c. A large proportion of the patients in the facility has been transferred from a state mental institution for continuing treatment of their mental disorders.

d. Independent review teams report a preponderance of mental illness in the diagnoses of the patients in the facility.

e. The average patient age is significantly lower than that of a typical nursing home.

f. Part or all of the facility consists of locked wards.

85.1(2) *Psychiatric hospitals serving persons under the age of 21.* A psychiatric hospital serving persons under the age of 21 shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B) or shall be licensed in another state as a hospital, shall be accredited by the Joint

Commission on the Accreditation of Health Care Organizations, the Commission of Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals, and shall meet federal service requirements.

441—85.2(249A) Out-of-state placement. Placement in an out-of-state psychiatric hospital for acute care requires prior approval by the bureau of managed care and clinical services and shall be approved only if special services are not available in Iowa facilities as determined by the division of behavioral, developmental, and protective services for families, adults, and children.

441—85.3(249A) Eligibility of persons under the age of 21.

85.3(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric hospital, the person shall be under 21 years of age. When treatment in the hospital is provided immediately preceding the person's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.3(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status the eligible person is entitled to the full scope of Medicaid benefits.

85.3(3) *Certification of need for care.* For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

a. For persons eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.3(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by a psychiatric facility, persons under the age of 21 must be eligible under one of the coverage groups listed in rule 441—75.1(249A).

441—85.4(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by an institution for mental disease, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A).

441—85.5(249A) Client participation.

85.5(1) *Before July 2005.* For months before July 2005, the resident shall be liable to pay client participation toward the cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

85.5(2) *July 2005 and after.* Effective with the month of July 2005, the resident shall not be liable to pay client participation toward the cost of care, and no client participation amount shall be deducted from the state payment to the hospital.

441—85.6(249A) Responsibilities of hospitals.

85.6(1) *Medical record requirements.* The medical records maintained by the psychiatric hospital shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the hospital.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within 60 hours of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires acute psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care general hospital, or enters the facility after 30 consecutive days of visitation.

85.6(2) *Fiscal records.*

a. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized in a general hospital, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.6(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. Active treatment. Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

b. Individual plan of care. An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph *"c"* below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

c. Interdisciplinary team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

441—85.7(249A) Psychiatric hospital reimbursement.

85.7(1) *Reimbursement formula.* Acute care in psychiatric hospitals shall be reimbursed on a per diem rate based on Medicare principles.

a. The reimbursement principles follow and comply with the retrospective Principles of Medicare reimbursement found in Title 18 of the Social Security Act and amendments to that Act, Medicare regulations found in the Health Insurance Regulation Manual (HIRM-1), and General Instructions-Health Insurance Manual sections 10, 11, 12 and 15 when applicable.

b. Allowable costs are those defined as allowable in 42 CFR, Subpart A, Sections 413.5 and 413.9, as amended to December 2, 1996, and 42 CFR 447.250 as amended to September 23, 1992. Only those costs are considered in calculating the Medicaid inpatient reimbursement.

c. Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost and to adhere to all Medicare cost principles in the calculation of the facility rates.

d. Payment for inpatient hospital care for recipients for whom the PRO has determined that the level of care that is medically necessary is only that of skilled care or nursing care will be made at a rate equal to the statewide average Medicaid skilled nursing facility rate or the average state nursing facility rate. Periodic PRO determinations of the need for continuing care are also required.

e. Each participating Medicaid provider shall file a CMS 2552 Medicare Cost Report or a substitute accepted by the Centers for Medicare and Medicaid Services. In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the Iowa Medicaid enterprise provider audits and rate-setting unit for Iowa within 150 days after the close of the hospital's fiscal year.

f. Compensation for a disproportionate share of indigent patients is determined as described in 441—subrule 79.1(5).

g. Medicaid reimbursement shall be reduced by any payments from a third party toward the cost of a patient's care.

85.7(2) *Medical necessity.* The medical necessity of admission and continued stay will be determined by the PRO. Payment shall not be made for admissions which are determined not to be medically necessary nor will payment be approved for stays beyond the time at which inpatient specialized hospital care at the acute level has been determined not to be medically necessary.

85.7(3) *Reserve bed day payment.* No reserve bed day payments are made to acute care psychiatric hospitals.

85.7(4) *Outpatient services.* No coverage is available for outpatient psychiatric hospital services.

These rules are intended to implement Iowa Code section 249A.4.

441—85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64.

85.8(1) *Facility.* Acute care in a psychiatric hospital is covered for persons aged 21 through 64 only at the state mental health institutes at Cherokee, Clarinda, Independence, and Mount Pleasant.

85.8(2) *Basis of eligibility.* To be eligible for payment for the cost of care provided by one of the covered facilities, a person aged 21 through 64 must be either:

a. Eligible for one of the coverage groups listed in 441—75.1(249A); or

b. Eligible under the IowaCare program pursuant to 441—Chapter 92.

85.8(3) *Period of eligibility.* A person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of discharge.

85.8(4) *Extent of eligibility.*

a. While on inpatient status, a person eligible under a coverage group listed in 441—75.1(249A) is entitled to the full scope of Medicaid benefits.

b. While on inpatient status, a person eligible under the IowaCare program is entitled to the services listed at 441—92.8(249A,81GA,ch167).

441—85.9 to **85.20** Reserved.

DIVISION II
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

441—85.21(249A) Conditions for participation. Psychiatric medical institutions for children shall be issued a license by the department of inspections and appeals under Iowa Code chapter 135H and shall hold either a license from the department of human services under Iowa Code section 237.3, subsection 2, paragraph *"a,"* subparagraph (3) or, for facilities which provide substance abuse treatment, a license from the department of public health under Iowa Code section 125.13.

This rule is intended to implement Iowa Code sections 135H.4 and 249A.4.

441—85.22(249A) Eligibility of persons under the age of 21.

85.22(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric medical institution for children, the person shall be under 21 years of age. When treatment in the facility is provided immediately preceding the individual's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.22(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status, the eligible individual is entitled to the full scope of Medicaid benefits.

85.22(3) *Certification for need for care.* For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

a. For persons determined eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.22(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by psychiatric medical institutions, persons under the age of 21 shall be eligible under one of the coverage groups listed in rule 441—75.1(249A), except medically needy.

441—85.23(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

441—85.24(249A) Responsibilities of facilities.

85.24(1) *Medical record requirements.* The medical records maintained by psychiatric medical institutions for children shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the facility.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is admitted.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within seven days of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's stay at the facility and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires psychiatric medical institution level of care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.24(2) *Fiscal records.*

a. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.24(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. Active treatment. Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

b. Individual plan of care. An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph *"c"* below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

c. Interdisciplinary team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility. Membership in the interdisciplinary plan of care team includes those physicians and other professionals who are involved in the direct provision of treatment services, involved in the organization of the plan of care, or involved in consulting with or supervising those professionals involved in the direct provision of care.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

441—85.25(249A) Reimbursement to psychiatric medical institutions for children.

85.25(1) *Computation of inpatient rate.* Facilities are paid at a per diem rate based on the facility's actual and allowable cost for the service not to exceed the upper limit as provided in 441—subrule 79.1(2).

a. Rates for new facilities are based on historical costs submitted on Form 470-0664, Financial and Statistical Report for Purchase of Service Contracts, if the institution is established and has the historical data. If the institution is newly established, the rate shall be based on a proposed budget submitted on

Form 470-0664. A Form 470-0664 with actual cost data shall be submitted after at least six months of participation in the program for a new rate adjustment.

b. After the initial cost report period, the institution shall submit Form 470-0664 annually within three months of the close of the facility's fiscal year. Failure to submit the report within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

c. For services rendered on or after August 1, 2011, rates paid shall be adjusted to 100 percent of the facility's actual and allowable average costs per patient day, based on the cost information submitted pursuant to paragraphs 85.25(1)*"a"* and *"b,"* subject to the upper limit provided in 441—subrule 79.1(2) for non-state-owned facilities. Before rate adjustment, providers shall be paid a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate.

85.25(2) *Reserve bed payments.*

a. Reserve bed day payment for days a resident of a psychiatric medical institution for children is absent from the facility for hospitalization in an acute care general hospital is paid in accordance with the following policies:

(1) The intent of the department and the facility shall be for the resident to return to the facility after the hospitalization.

(2) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the hospitalization.

(3) Payment for reserve bed days shall be canceled and payment returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment will not be authorized for over ten days per calendar month and will not be authorized for over ten days for any continuous hospital stay.

b. Reserve bed days for visitation shall be made for days a resident is absent from a psychiatric medical institution for children at the time of a nightly census for the purpose of visitation when the absence is in accordance with the following policies:

(1) The visits are consistent with the child's case permanency plan and the facility's individual case plan.

(2) The intent of the department and the facility shall be for the child to return to the facility after the visitation.

(3) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the visit.

(4) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment for reserve bed days shall be canceled effective the day after a decision not to return the child is made by the court or, in a voluntary placement, by the parent.

(6) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

c. Reserve bed payment shall be made for days a resident is absent from a psychiatric medical institution for children at the time of the nightly census for reasons such as detention, shelter care, or running away when the absence is in accordance with the following policies:

(1) The intent of the department and the psychiatric medical institution for children shall be for the child to return to the facility after the absence.

(2) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the

child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(3) Payment for reserve bed days shall be canceled effective the day after a decision is made not to return the child by the court or, in a voluntary placement, by the parent.

(4) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

(5) Reserve bed day payment is not available until the child has been physically admitted to the psychiatric medical institution.

(6) The psychiatric medical institution shall notify the department social worker within 24 hours after the child is out of the facility for running away or other unplanned reasons.

85.25(3) *Day treatment rates.* Outpatient day treatment services are paid on a fixed fee basis.

[**ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 0028C**, IAB 3/7/12, effective 4/11/12]

441—85.26(249A) Outpatient day treatment for persons aged 20 or under. Payment to a psychiatric medical institution for children will be approved for day treatment services for persons aged 20 or under if the psychiatric medical institution for children is certified by the department of inspections and appeals for day treatment services and the services are provided on the licensed premises of the psychiatric medical institution for children.

EXCEPTION: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan. All conditions for the day treatment program for persons aged 20 or under as outlined in 441—subrule 78.16(7) for community mental health centers shall apply to psychiatric medical institutions for children.

These rules are intended to implement Iowa Code section 249A.4.

441—85.27 to **85.40** Reserved.

DIVISION III
NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

441—85.41(249A) Conditions of participation. A nursing facility for persons with mental illness shall be licensed pursuant to department of inspections and appeals rules 481—Chapter 65, or, if the facility is a distinct part of a hospital, pursuant to department of inspections and appeals rule 481—51.33(135B). A distinct part of a general hospital may be considered a psychiatric institution. In addition, the facility shall be certified to participate in the Iowa Medicaid program as a nursing facility pursuant to 441—Chapter 81 and shall be 16 beds or more. The facility shall also meet the criteria set forth in subrule 85.1(1).

441—85.42(249A) Out-of-state placement. Placement in out-of-state nursing facilities for persons with mental illness is not payable.

441—85.43(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by nursing facilities for persons with mental illness, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A), except for medically needy.

441—85.44(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

441—85.45(249A) Responsibilities of nursing facility.

85.45(1) *Medical record requirements.* The facility shall obtain a PRO determination that the person requires psychiatric care when a person applying or eligible for Medicaid enters the facility, returns

from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.45(2) *Fiscal records.*

a. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

441—85.46(249A) Policies governing reimbursement. Cost reporting, reserve bed day payment, and reimbursement shall be the same for nursing facilities for persons with mental illness as for nursing facilities as set forth in 441—Chapter 81.

441—85.47(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with mental illness who has countable income for purposes of rule 441—75.16(249A) of less than $50 per month shall receive a state-funded payment from the department for the difference between that countable income and $50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

These rules are intended to implement Iowa Code section 249A.4.

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CHAPTER 109
CHILD CARE CENTERS

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[Prior to 7/1/83, Social Services[770] Ch 109]
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PREAMBLE

The intent of this chapter is to specify minimum requirements for licensed child care centers and preschools and to define those child-caring environments that are governed by the licensing standards. The licensing standards govern licensing procedures, administration, parental participation, personnel, records, health and safety policies, physical facilities, activity programs, and food services.

441—109.1(237A) Definitions.

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

"Child" means either of the following:

1. A person 12 years of age or younger.
2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

"Child care" means the care, supervision, or guidance of a child by a person other than the parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis in a place other than the child's home, but does not include care, supervision, or guidance of a child by any of the following:

1. An instructional program administered by a public or nonpublic school system accredited by the department of education or the state board of regents or a program provided under Iowa Code sections 279.49 and 280.3A.
2. Any of the following church-related programs:

- An instructional program.
- A youth program other than a preschool, before or after school child care program, or other child care program.
- A program providing care to children on church premises while the children's parents are attending church-related or church-sponsored activities on the church premises.

3. Short-term classes of less than two weeks' duration held between school terms or during a break within a school term.
4. A child care center for sick children operated as part of a pediatrics unit in a hospital licensed by the department of inspections and appeals pursuant to Iowa Code chapter 135B.
5. A program operated not more than one day per week by volunteers that meets all the following conditions:

- Not more than 11 children are served per volunteer.
- The program operates for less than 4 hours during any 24-hour period.
- The program is provided at no cost to the children's parent, guardian, or custodian.

6. A nationally accredited camp.
7. A program administered by a political subdivision of the state which is primarily for recreational or social purposes and is limited to children who are five years of age or older and attending school.
8. An instructional program for children at least four years of age who are attending prekindergarten, as defined by the state board of education, or a higher grade level, administered by a nonpublic school system which is not accredited by the department of education or the state board of regents.
9. An after-school program continuously offered throughout the school year to children who are at least five years of age and enrolled in school and attend the program intermittently, or a summer-only program for such children. The program must be provided through a nominal membership fee or at no cost.

10. A special activity program which meets less than four hours per day for the sole purpose of the special activity. Special activity programs include but are not limited to music or dance classes, organized athletic or sports programs, recreational classes, scouting programs, and hobby or craft clubs or classes.

11. A structured program for the purpose of providing therapeutic, rehabilitative, or supervisory services to children under any of the following:

- A purchase of service or managed care contract with the department.
- A contract approved by a local decategorization governance board.
- An arrangement approved by a juvenile court order.

12. Care provided on site to children of parents residing in an emergency, homeless, or domestic violence shelter.

13. A child care facility providing respite care to a licensed foster family home for a period of 24 hours or more to a child who is placed with that licensed foster family home.

14. A program offered to a child whose parent, guardian, or custodian is engaged solely in a recreational or social activity, remains immediately available and accessible on the physical premises on which the child's care is provided, and does not engage in employment while the care is provided. However, if the recreational or social activity is provided in a fitness center or on the premises of a nonprofit organization, the parent, guardian, or custodian of the child may be employed to teach or lead the activity.

"Child care center" or *"center"* means a facility providing child day care for seven or more children, except when the facility is registered as a child development home. For the purposes of this chapter, the word "center" shall apply to a child care center or preschool, unless otherwise specified.

"Child care facility" or *"facility"* means a child care center, a preschool, or a registered child development home.

"Department" means the department of human services.

"Direct responsibility for child care" means being charged with the care, supervision, or guidance of a child.

"Extended evening care" means child care provided by a child care center between the hours of 9 p.m. and 5 a.m.

"Facility" means a building or physical plant established for the purpose of providing child day care.

"Get-well center" means a facility that cares for a child with an acute illness of short duration for short enrollment periods.

"Involvement with child care" means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

"National Health and Safety Performance Standards" means the National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs produced by the American Public Health Association and the American Academy of Pediatrics with the support of the Maternal and Child Health Bureau, Department of Health and Human Services.

"Parent" means parent or legal guardian.

"Person subject to an evaluation" means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for licensure or is licensed.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.

"Preschool" means a child day care facility which provides care to children aged three through five, for periods of time not exceeding three hours per day. The preschool's program is designed to help the children develop intellectual, social and motor skills, and to extend their interest in and understanding of the world about them.

"Regulatory fee" means the amount payable to the department for licensure of a child care center based on the capacity of the center.

"Transgression" means the existence of any of the following in a person's record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person's continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

"Unrestricted access" means that a person has contact with a child alone or is directly responsible for child care.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10; **ARC 0030C**, IAB 3/7/12, effective 5/1/12]

441—109.2(237A) Licensure procedures.

109.2(1) *Application for license.*

a. Any adult or agency has the right to apply for a license. The application for a license shall be made to the department on Form 470-0722, Application for a License to Operate a Child Care Center, provided by the department.

b. Requested reports including the fire marshal's report and other information relevant to the licensing determination shall be furnished to the department upon application and renewal. A building owned or leased by a school district or accredited nonpublic school that complies with rules adopted by the state fire marshal for school buildings under 661—Chapter 5 is considered appropriate for use by a child care facility.

c. When a center makes a sufficient application for an initial license, it may operate for a period of up to 120 calendar days from the date of issuance of Form 470-4690, Permission to Open Without a License, pending a final licensing decision. A center has made a sufficient application when it has submitted the following to the department:

(1) An application for a license.

(2) An approved fire marshal's report.

(3) A floor plan indicating room descriptions and dimensions, including location of windows and doors.

(4) Information sufficient to determine that the center director meets minimum personnel qualifications.

d. Applicants shall be notified of approval or denial of initial applications within 120 days from the date the application is submitted.

(1) If the applicant has been issued Form 470-4690, Permission to Open Without a License, the applicant shall be notified of approval or denial within 120 calendar days of the date of issuance of Form 470-4690.

(2) No full or provisional license shall be issued before payment of the applicable regulatory fee as determined pursuant to subrule 109.2(7).

e. The department shall not act on a licensing application for 12 months after an applicant's child care center license has been denied or revoked.

f. When the department has denied or revoked a license, the applicant or person shall be prohibited from involvement with child care unless the department specifically permits involvement through a record check decision.

109.2(2) *License.*

a. An applicant showing full compliance with center licensing laws and these rules, including department approval of center plans and procedures and submission of the regulatory fee as specified in subrule 109.2(7) to the department by the date due, shall be issued a license for 24 months. In determining whether or not a center is in compliance with the intent of a licensing standard outlined in this chapter, the department shall make the final decision.

b. A new license shall be applied for when the center moves, expands, or the facility is remodeled to change licensed capacity.

c. A new license shall be applied for when another adult or agency assumes ownership or legal responsibility for the center.

109.2(3) *Provisional license.*

a. A provisional license may be issued or a previously issued license may be reduced to a provisional license for a period up to one year when the center does not meet all standards imposed by law and these rules.

b. A provisional license shall be renewable when written plans giving specific dates for completion to bring the center up to standards are submitted to and approved by the department. A provisional license shall not be reissued for more than two consecutive years when the lack of compliance with the same standards has not been corrected within two years.

c. When the center submits documentation or it can otherwise be verified that the center fully complies with all standards imposed by law or these rules, the license shall be upgraded to a full license.

109.2(4) *Denial.* Initial applications or renewals shall be denied when:

a. The center does not comply with center licensing laws and these rules in order to qualify for a full or provisional license.

b. The center is operating in a manner which the department determines impairs the safety, health, or well-being of children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided either orally or in writing to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The center is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal in 661—Chapter 5 or Iowa Code chapter 100 or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(7) is not received by the department's division of fiscal management by the due date indicated on Form 470-4834, Child Care Center Licensing Fee Invoice.

109.2(5) *Revocation and suspension.* A license shall be revoked or suspended if corrective action has not been taken when:

a. The center does not comply with center licensing laws or these rules.

b. The center is operating in a manner which the department determines impairs the safety, health, or well-being of the children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The facility is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal in 661—Chapter 5 or Iowa Code chapter 100 or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(7) is not paid in full due to insufficient funds to cover a check submitted to the department for the fee.

109.2(6) *Adverse actions.*

a. Notice of adverse actions for a denial, revocation, or suspension and the right to appeal the licensing decision shall be given to applicants and licensees in accordance with 441—Chapter 7.

b. An applicant or licensee affected by an adverse action may request a hearing by means of a written request directed to the Department of Human Services, Appeals Section, 1305 E. Walnut Street, Fifth Floor, Des Moines, Iowa 50319-0114. The request shall be submitted within 30 days after the date the department mailed the official notice containing the nature of the denial, revocation, or suspension.

c. A letter received by an owner or director of a licensed center initiating action to deny, suspend, or revoke the facility's license shall be conspicuously posted at the main entrance to the facility where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny, suspend or revoke the license. If the action to deny, suspend, or revoke is upheld, the center shall return the license to the department.

d. If the center's license is denied, suspended or revoked, the department shall notify the parent, guardian, or legal custodian of each child for whom the facility provides child care. The center shall cooperate with the department in providing the names and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

109.2(7) *Regulatory fees.* For relicensures with an effective date on or after August 1, 2010, as indicated on the license certificate, and for initial applications for licensure submitted on or after June 1, 2010, a fee based upon center capacity is due to the department before the issuance of the license in accordance with this subrule.

a. Fee structure. The amount of the fee is based on the capacity of the center as indicated below:

Center Capacity	Fee Amount
0 to 20 children	$50
21 to 50 children	$75
51 to 100 children	$100
101 to 150 children	$125
151 or more children	$150

b. Determination of capacity. The licensing consultant shall determine center capacity by dividing the amount of usable space by the amount of space required per child, as specified in subrule 109.11(1) and subparagraphs 109.11(3)*"a"*(2) and (3). Upon approval by the department, the final determination of center capacity may include evaluation of other factors that influence capacity, as long as physical space requirements per child as defined in subrule 109.11(1) and subparagraphs 109.11(3)*"a"*(2) and (3) are maintained.

c. Notification. Upon final determination of center capacity by the licensing consultant, the licensing consultant or designee shall sign and provide Form 470-4834, Child Care Center Licensing Fee Invoice, to the center.

d. Payment. The center shall return Form 470-4834 to the department with the licensing fee payment within 30 calendar days from the date of the licensing consultant's or designee's signature on Form 470-4834. Payment may be in the form of cash, check, money order, or cashier's check.

(1) Payment must be received before the department will issue a full or provisional license.

(2) Regulatory fees are nonrefundable and nontransferrable.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10]

441—109.3(237A) Inspection and evaluation. The department shall conduct an on-site visit in order to make a licensing recommendation for all initial and renewal applications for licensure and shall determine compliance with licensing standards imposed by licensing laws and these rules when a complaint is received.

109.3(1) At least one unannounced on-site visit shall be conducted each calendar year.

109.3(2) After each visit and complaint, the department shall document whether a center was in compliance with center licensing standards imposed by licensing laws and these rules.

109.3(3) The written documentation of the department's conclusion as to whether a center was in compliance with licensing standards for all licensing visits and complaints shall be available to the public. However, the identity of the complainant shall be withheld unless expressly waived by the complainant.

441—109.4(237A) Administration.

109.4(1) *Purpose and objectives.* Incorporated and unincorporated centers shall submit a written statement of purpose and objectives. The plan and practices of operation shall be consistent with this statement.

109.4(2) *Required written policies.* The child care center owner, board or director shall:

a. Develop fee policies and financial agreements for the children served.

b. Develop and implement policies for enrollment and discharge of children, field trips and non-center activities, transportation, discipline, nutrition, and health and safety policies.

c. Develop a curriculum or program structure that uses developmentally appropriate practices and an activity program appropriate to the developmental level and needs of the children.

d. Develop and implement a written plan for staff orientation to the center's policies and to the provisions of 441—Chapter 109 where applicable to staff.

e. Develop and implement a written plan for ongoing training and staff development in compliance with professional growth and development requirements established by the department in rule 441—109.7(237A).

f. Make available for review a copy of the center policies and program to all staff at the time of employment and each parent at the time a child is admitted to the center. A copy of the fee policies and financial agreements shall be provided to each parent at the time a child is admitted to the center.

g. Develop and implement a policy for responding to incidents of biting that includes the following elements.

(1) An explanation of the center's perspective on biting.

(2) A description of how the center will respond to individual biting incidents and episodes of ongoing biting.

(3) A description of how the center will assess the adequacy of caregiver supervision and the context and the environment in which the biting occurred.

(4) A description of how the center will respond to the individual child or caregiver who was bitten.

(5) A description of the process for notification of parents of children involved in the incident.

(6) A description of how the incident will be documented.

(7) A description of how confidentiality will be protected.

(8) A description of first-aid procedures that the center will use in response to biting incidents.

h. Develop a policy to ensure that people do not have unauthorized access to children at the center. The policy shall be subject to review for minimum safety standards by the licensing consultant. The policy shall include but is not limited to the following:

(1) The center's criteria for allowing people to be on the property of the facility when children are present.

(2) A description of how center staff will supervise and monitor people who are permitted on the property of the center when children are present, but who have not been cleared for involvement with child care through the formal record check process as outlined in subrule 109.6(6). The description shall include definitions of "supervision" and "monitoring."

(3) A description of how responsibility for supervision and monitoring of people in the center will be delegated to center staff, which includes provisions that address conflicts of interest.

(4) A description of how the policy will be shared with parents, guardians, and custodians of all children who are enrolled at the center.

109.4(3) *Required postings.*

a. Postings are required for the certificate of license, notice of exposure of children to a communicable disease, and notice of actions to deny, suspend, or revoke the center's license and shall be conspicuously placed at the main entrance to the center. If the center is located in a building used for additional purposes and shares the main entrance to the building, the required postings shall be conspicuously placed in the center in an area that is frequented daily by parents or the public.

b. Postings are required for mandatory reporter requirements, the notice of availability of the handbook required in subrule 109.4(5), and the program activities and shall be placed in an area that is frequented daily by parents or the public.

109.4(4) *Mandatory reporters.* Requirements and procedures for mandatory reporting of suspected child abuse as defined in Iowa Code section 232.69 shall be posted where they can be read by staff and parents. Methods of identifying and reporting suspected child abuse and neglect shall be discussed with all staff within 30 days of employment.

109.4(5) *Handbook.* A copy of Form SS-0711, Child Care Centers and Preschools Licensing Standards and Procedures, shall be available in the center, and a notice stating that a copy is available for review upon request from the center director shall be conspicuously posted. The name, office mailing address and telephone number of the child care consultant shall be included in the notice.

109.4(6) *Certificate of license.* The child care license shall be posted in a conspicuous place and shall state the particular premises in which child care may be offered and the number of children who may be cared for at any one time. Notwithstanding the requirements in rule 441—109.8(237A), no greater number of children than is authorized by the license shall be cared for at any one time.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10]

441—109.5(237A) Parental participation.

109.5(1) *Unlimited access.* Parents shall be afforded unlimited access to their children and to the provider caring for their children during the center's hours of operation or whenever their children are in the care of a provider, unless parental contact is prohibited by court order. The provider shall inform all parents of this policy in writing at the time the child is admitted to the center.

109.5(2) *Parental evaluation.* If requested by the department, centers shall assist the department in conducting an annual survey of parents being served by their center by providing to parents Form 470-3409, Parent Survey: Child Care Centers. The department shall notify centers of the time frames for distribution and completion of the survey and the procedures for returning the survey to the department. The purpose of the survey shall be to increase parents' understanding of developmentally appropriate and safe practice, solicit statewide information regarding parental satisfaction with the quality of care being provided to children and obtain the parents' perspective regarding the center's compliance with licensing requirements.

441—109.6(237A) Personnel. The board or director of the center shall develop policies for hiring and maintaining staff that demonstrate competence in working with children and that meet the following minimum requirements:

109.6(1) *Center director requirements.* Centers that have multiple sites shall have a center director or on-site supervisor in each center. The center director is responsible for the overall functions of the center, including supervising staff, designing curriculum and administering programs. The director shall ensure services are provided for the children within the framework of the licensing requirements and the center's statement of purpose and objectives. The center director shall have overall responsibility for carrying out the program and ensuring the safety and protection of the children. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the director meets the following minimum qualifications:

a. Is at least 21 years of age.

b. Has obtained a high school diploma or passed a general education development test.

c. Has completed at least one course in business administration or 12 contact hours in administrative-related training related to personnel, supervision, record keeping, or budgeting or has one year of administrative-related experience.

d. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa's training for the mandatory reporting of child abuse.

e. Has achieved a total of 100 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT-RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 100 points, a minimum of two categories must be used, no more than 75 points may be achieved in any one category, and at least 20 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For directors in centers predominantly serving children with special needs, the directors may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For directors in centers serving predominantly school-age children, the directors may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.6(2) *On-site supervisor.* The on-site supervisor is responsible for the daily supervision of the center and must be on site daily either during the hours of operation that children are present or a minimum of eight hours of the center's hours of operation. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the on-site supervisor meets the following minimum qualifications:

a. Is an adult.

b. Has obtained a high school diploma or passed a general education development test.

c. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa's mandatory reporting of child abuse.

d. Has achieved a total of 75 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT-RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 75 points, a minimum of two categories must be used, no more than 50 points may be achieved in any one category, and at least 10 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For on-site supervisors in centers predominantly serving children with special needs, the on-site supervisor may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For on-site supervisors in centers serving predominantly school-age children, the on-site supervisor may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.6(3) *Director and on-site supervisor functions combined.* In a center where the functions of the center director and the on-site supervisor are accomplished by the same person, the educational and experience requirements for a center director shall apply. If the center director is serving in the role of the on-site supervisor, the director shall be on site daily either during the hours of operation or a minimum of at least eight hours of the center's hours of operation. If the staff person designated as the on-site supervisor is temporarily absent from the center, another responsible adult staff shall be designated as the interim on-site supervisor.

109.6(4) *Transition period for staff.* In achieving the qualifications outlined in rule 441—109.6(237A), staff hired prior to April 1, 1998, shall obtain the education, experience or child-developmental training sufficient to meet the required point totals by April 1, 1999.

109.6(5) *Volunteers and substitutes.* A volunteer shall be at least 16 years of age. All volunteers and substitutes shall:

a. Sign a statement indicating whether or not they have one of the following:

(1) A conviction of any law in any state or any record of founded child abuse or dependent adult abuse in any state.

(2) A communicable disease or other health concern that could pose a threat to the health, safety, or well-being of the children.

b. Sign a statement indicating the volunteer or substitute has been informed of the volunteer's or substitute's responsibilities as a mandatory reporter.

c. Undergo the record check process when any of the following criteria are met:

(1) The volunteer or substitute is included in meeting the required child-to-staff ratio;

(2) The volunteer or substitute has direct responsibility for a child or children; or

(3) The volunteer or substitute has access to a child or children with no other staff present.

d. Have on file at the facility a record containing the statements required in paragraphs 109.6(5)*"a"* and *"b"* and documentation of any record check process. The record shall be maintained as required in paragraph 109.9(1)*"b."*

109.6(6) *Record checks.*

a. Applicability.

(1) Criminal and child abuse record checks shall be conducted for:

1. Each owner, director, staff member, substitute, volunteer, or subcontracted staff person with direct responsibility for child care or with access to a child when the child is alone;

2. Anyone living in the child care facility who is 14 years of age or older.

(2) Parents, guardians, and custodians are exempt from the record check process in relation to access to their own children or wards.

(3) Professional staff who hold a current, valid license issued by the educational examiners board are exempt from the record check process in relation to children in the center to whom they provide professional services consistent with Iowa Code chapter 272 and rules adopted by the educational examiners board.

b. Authorization. The person subject to record checks shall complete Form 595-1396, DHS Criminal History Record Check Form B, and any other forms required by the department of public safety to authorize the release of records.

c. Iowa records checks. Checks and evaluations of Iowa child abuse and criminal records, including the sex offender registry, shall be completed before the person's involvement with child care at the center. Iowa records checks shall be repeated at a minimum of every two years and when the department or the center becomes aware of any possible transgressions. The department is not responsible for the cost of conducting the Iowa records check.

(1) The child care center may access the single-contact repository (SING) as necessary to conduct a criminal and child abuse record check of the person in Iowa. If the results of the check indicate a potential transgression, the center shall send a copy of the results to the department for determination of whether or not the person may be involved with child care, regardless of the person's status with the center.

(2) Unless a record check has already been conducted in accordance with subparagraph (1), the department shall conduct a criminal and child abuse record check in Iowa for a person who is subject to a record check. When the department conducts the records check, the fee shall be $25 for each record check through June 30, 2010, and $35 effective July 1, 2010. The center shall submit the fee before the department initiates the record check process. Payment must be in the form of cash, check, money order, or cashier's check. The department may access SING to conduct the records check. The department may also conduct dependent adult abuse, sex offender, and other public or civil offense record checks in Iowa for a person who is subject to a record check.

(3) Centers that participate in student intern programs may seek a waiver for substitution of the state record check process with a check performed by the student's educational institution. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

d. National criminal history checks. National criminal history checks based on fingerprints are required for all persons subject to record checks under this subrule effective with a center's initial licensure or relicensure on or after June 1, 2010. The national criminal history check shall be repeated for each person every four years and when the department or center becomes aware of any new

transgressions committed by that person in another state. The department is not responsible for the cost of conducting the national criminal history check.

(1) The child care center is responsible for obtaining the fingerprints of all persons subject to record checks. Fingerprints may be taken by law enforcement agencies, by agencies or companies that specialize in taking fingerprints, or by center staff or subcontractors who have received appropriate training in the taking of fingerprints.

(2) If the results of the Iowa records checks do not warrant prohibition of the person's involvement with child care or otherwise present protective concerns, the person may be involved with child care on a provisional basis until the national criminal history check and evaluation have been completed.

(3) The child care center shall provide fingerprints to the department of public safety no later than 30 days after the subject's approval for employment at the center. The center shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(4) Centers that are required to submit fingerprint-based checks of the FBI national criminal database to comply with federal regulations may seek a waiver to substitute that record check for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(5) Centers that participate in student intern programs may seek a waiver to substitute the fingerprint-based check of the FBI national criminal database performed by the student's educational institution for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(6) A center considering involvement of a person who has had a national criminal history check at another center may request information from that center. That center may provide the following information in writing upon a center's request, using Form 470-4896, National Criminal History Check Confirmation:

1. Date of most recent national criminal history check conducted by the center on the person in question, and

2. Whether or not the national check process resulted in clearance of the person for involvement with child care.

(7) If the results of the national criminal history check indicate that the person has committed a transgression, the center, if interested in continuing the person's involvement in child care, shall send a copy of the results to the department for evaluation. The department shall determine whether or not the person may be involved with child care.

(8) A center shall submit all required fingerprints to the department of public safety before the issuance or renewal of the center's license on or after June 1, 2010. EXCEPTION: Centers that have an initial or renewal licensure date of June 1, 2010, shall have until July 1, 2010, to submit the fingerprints to the department of public safety.

e. Mandatory prohibition. A person with the following convictions or founded abuse reports is prohibited from involvement with child care:

(1) Founded child or dependent adult abuse that was determined to be sexual abuse.

(2) Placement on the sex offender registry.

(3) Felony child endangerment or neglect or abandonment of a dependent person.

(4) Felony domestic abuse.

(5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.

(6) Forcible felony.

f. Mandatory time-limited prohibition.

(1) A person with the following convictions or founded abuse reports is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.

2. Founded child abuse that was determined to be physical abuse.

(2) After the five-year prohibition period imposed pursuant to 109.6(6)*"f"*(1), the person may request the department to perform an evaluation under paragraph 109.6(6)*"g"* to determine whether prohibition of the person's involvement with child care continues to be warranted.

g. Evaluation required. For all other transgressions, and as requested under subparagraph 109.6(6)*"f"*(2), the department shall notify the affected person and the licensee that an evaluation shall be conducted to determine whether prohibition of the person's involvement with child care is warranted.

(1) The person with the transgression shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and return this form by the specified date shall result in denial or revocation of the license or denial of employment.

(2) The department may use information from the department's case records in performing the evaluation.

(3) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression in relation to the position sought or held.
2. The time elapsed since the commission of the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

h. Evaluation decision. Within 30 days of receipt of a completed Form 470-2310, Record Check Evaluation, the department shall make a decision on the person's involvement with child care. The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements and corrective action plan under this paragraph.

(1) The department shall mail to the individual on whom the evaluation was completed Form 470-2386, Record Check Decision, that explains the decision reached regarding the evaluation of the transgression and Form 470-0602, Notice of Decision.

(2) If the department determines through an evaluation of a person's transgressions that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(3) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions and corrective action plan relating to the person's involvement with child care.

(4) The department shall send a letter to the employer that informs the employer whether the person subject to an evaluation has been approved or denied involvement with child care. If the person has been approved, the letter shall inform the employer of any conditions and corrective action plan relating to the person's involvement with child care.

i. Notice to parents. The department shall notify the parent, guardian, or legal custodian of each child for whom the person provides child care if there has been founded child abuse committed by an owner, director, or staff member of the child care center. The center shall cooperate with the department in providing the names and addresses of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

109.6(7) *Use of controlled substances and medications.* All owners, personnel, and volunteers shall be free of the use of illegal drugs and shall not be under the influence of alcohol or of any prescription or nonprescription drug that could impair their ability to function.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10; **ARC 9441B**, IAB 4/6/11, effective 6/1/11]

441—109.7(237A) Professional growth and development. The center director, on-site supervisor, and staff counted as part of the staff ratio shall meet the following minimum staff training requirements:

109.7(1) *Required training within the first six months of employment.* During their first six months of employment, all staff shall receive the following training:

a. Two hours of Iowa's training for mandatory reporting of child abuse.

b. At least one hour of training regarding universal precautions and infectious disease control.

109.7(2) *Center directors and staff employed 20 hours or more per week.* The requirements of this subrule apply to all center directors, regardless of whether the director works on a full-time or part-time basis.

a. During their first year of employment, all center directors and all staff employed 20 hours or more per week shall receive the following training:

(1) Certification in American Red Cross or American Heart Association infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

(2) Certification in infant, child, and adult first aid that uses a nationally recognized curriculum or is received from a nationally recognized training organization including the American Red Cross, American Heart Association, the National Safety Council, and Emergency Medical Planning (Medic First Aid) or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

(3) Ten contact hours of training from one or more of the following content areas:

1. Planning a safe, healthy learning environment (includes nutrition).
2. Steps to advance children's physical and intellectual development.
3. Positive ways to support children's social and emotional development (includes guidance and discipline).
4. Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).
5. Strategies to manage an effective program operation (includes business practices).
6. Maintaining a commitment to professionalism.
7. Observing and recording children's behavior.
8. Principles of child growth and development.

(4) At least four hours of the ten contact hours of training shall be received in a group setting as defined in subrule 109.7(7). Six hours may be received in self-study using a training package approved by the department as defined in subrule 109.7(8). Training received for cardiopulmonary resuscitation (CPR), first aid, mandatory reporting of child abuse, and universal precautions shall not count toward the ten contact hours. A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(5) Center directors and on-site supervisors shall receive all ten hours of training in a group setting as defined in subrule 109.7(7).

(6) Staff who have completed a comprehensive training package of at least ten contact hours offered through a child care resource and referral agency or community college within six months prior to initial employment shall have the first year's ten contact hours of training waived.

b. Following their first year of employment, all center directors and all staff who are employed 20 hours or more a week shall:

(1) Maintain current certification for Iowa's training for the mandatory reporting of child abuse; infant, child and adult CPR; and infant, child and adult first aid.

(2) Receive six contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2)*"a"*(3). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(3) Center directors and on-site supervisors shall receive eight contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2)*"a"*(3). At least four of the eight contact hours shall be in a group setting as defined in subrule 109.7(7).

109.7(3) *Staff employed less than 20 hours per week.*

a. During their first year of employment, all staff who are employed less than 20 hours a week shall receive the following training:

(1) Five contact hours of training from one or more of the following topical areas: child development, guidance and discipline, developmentally appropriate practices, nutrition, health and safety, communication skills, professionalism, business practices, and cross-cultural competence.

(2) At least two of the five contact hours shall be in a sponsored group setting.

(3) Staff who have completed a comprehensive training package of at least ten contact hours offered through a child care resource and referral agency or community college within six months prior to initial employment shall have the five contact hours required in the first year waived.

b. Following their first year of employment, all staff who are employed less than 20 hours a week shall:

(1) Maintain current certification for Iowa's training for mandatory reporting of child abuse.

(2) Receive four contact hours of training annually from one or more of the following topical areas: child development, guidance and discipline, developmentally appropriate practices, nutrition, health and safety, communication skills, professionalism, business practices, and cross-cultural competence. At least two of the four contact hours shall be in a sponsored group setting.

109.7(4) *Staff employed in centers that operate summer-only programs.* Staff who are employed in centers that operate only in the summer months when school is not in session shall receive the following training:

a. Two hours of Iowa's training for mandatory reporting of child abuse.

b. At least one hour of training regarding universal precautions and infectious disease control.

c. At least one staff person on duty in the center and outdoor play area when children are present and on field trips shall have certification in American Red Cross or American Heart Association infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

d. At least one staff person on duty in the center and outdoor play area when children are present and on field trips shall receive certification in infant, child and adult first aid that uses a nationally recognized curriculum or is received from a nationally recognized training organization including the American Red Cross, American Heart Association, the National Safety Council, and Emergency Medical Planning (Medic First Aid) or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

109.7(5) *Training plans.* Training shall supplement educational and experience requirements in rule 441—109.6(237A) and shall enhance the staff's skill in working with the developmental and cultural characteristics of the children served.

109.7(6) *Substitution.* A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

109.7(7) *Group training.* Training received in a group setting is not self-study, but is training received with other adults, either in or out of the child care center.

a. The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed or obtained with the written permission of one of the following entities:

(1) An accredited university or college.

(2) A community college.

(3) Iowa State University Extension.

(4) A child care resource and referral agency.

(5) An area education agency.

(6) The regents' center for early developmental education at the University of Northern Iowa.

(7) A hospital (for health and safety, first-aid, and CPR training).

(8) The American Red Cross, the American Heart Association, the National Safety Council, or Medic First Aid (for first-aid and CPR training).

(9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.

(10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for

Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.

(11) The Child and Adult Care Food Program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

(12) The Iowa department of public health, department of education, or department of human services.

(13) Head Start agencies or the Head Start technical assistance system.

b. Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph *"a"* or an entity approved under paragraph *"g."* Approved training shall be made available to Iowa child care providers through the child care provider training registry beginning July 1, 2009.

c. Training received in a group setting may include distance learning opportunities such as training conducted over the Iowa communications network, on-line courses, or Web conferencing (webinars) if:

(1) The training meets the requirements in subrule 109.7(9);

(2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and

(3) The training organization meets the requirements listed in this subrule or is approved by the department.

d. The department will not approve more than eight hours of training delivered in a single day.

e. The department may randomly monitor any state-approved training for quality control purposes.

f. Training conducted with staff either during the hours of operation of the facility, staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff shall not be actively engaged in care and supervision and simultaneously participate in training.

g. A training organization not approved by the department may submit training for approval to the department on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

109.7(8) *Self-study training.*

a. Self-study training packages approved by the department include curriculum developed and materials distributed by:

(1) Department child care licensing consultants,

(2) Iowa State University Extension, or

(3) A child care resource and referral agency.

b. Self-study training materials not distributed by these entities may be submitted by the training organization to the department for approval on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

109.7(9) *Approved training.* Training provided to Iowa child care providers shall offer:

a. Instruction that is consistent with:

(1) Iowa child care regulatory standards;

(2) The Iowa early learning standards; and

(3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

b. Content equal to at least one contact hour of training.

c. An opportunity for ongoing interaction and timely feedback, including questions and answers within the contact hours if training is delivered in a group setting.

d. A certificate of training for each participant that includes:

(1) The name of the participant.

(2) The title of the training.

(3) The dates of training.

(4) The content area addressed.
(5) The name of the training organization.
(6) The name of the instructor.
(7) The number of contact hours.
(8) An indication of whether the training was delivered through self-study or in a group setting.
[**ARC 8650B**, IAB 4/7/10, effective 6/1/10]

441—109.8(237A) Staff ratio requirements.

109.8(1) *Staff requirements.* Persons counted as part of the staff ratio shall meet the following requirements:

a. Be at least 16 years of age. If less than 18 years of age, the staff shall be under the direct supervision of an adult.

b. Be involved with children in programming activities.

c. At least one staff person on duty in the center and outdoor play area when children are present and present on field trips shall be over the age of 18 and hold current certification in first aid and cardiopulmonary resuscitation (CPR) as required in rule 441—109.7(237A).

109.8(2) *Staff ratio.* The staff-to-child ratio shall be as follows:

Age of children	Minimum ratio of staff to children
Two weeks to two years	One to every four children
Two years	One to every six children
Three years	One to every eight children
Four years	One to every twelve children
Five years to ten years	One to every fifteen children
Ten years and over	One to every twenty children

a. Combinations of age groupings for children four years of age and older may be allowed and may have staff ratio determined on the age of the majority of the children in the group. If children three years of age and under are included in the combined age group, the staff ratio for children aged three and under shall be maintained for these children. Preschools shall have staff ratios determined on the age of the majority of the children, including children who are three years of age.

b. If a child between the ages of 18 and 24 months is placed outside the infant area, as defined at subrule 109.11(2), the staff ratio of 1 to 4 shall be maintained as would otherwise be required for the group until the child reaches the age of two.

c. Every child-occupied program room shall have adult supervision present in the room.

d. During nap time, at least one staff shall be present in every room where children are resting. Staff ratio requirements may be reduced to one staff per room where children are resting for a period of time not to exceed one hour provided staff ratio coverage can be maintained in the center. The staff ratio shall always be maintained in the infant area.

e. The minimum staff ratio shall be maintained at mealtimes and for any outdoor activities at the center.

f. When seven or more children over the age of three are present on the licensed premises or are being transported in one vehicle, at least two adult staff shall be present. Only one adult is required when a center is transporting children in a center-owned vehicle with parent authorization for the sole purpose of transporting children to and from school. When a center contracts with another entity to provide transportation other than for the purpose of transporting school-age children to or from school, at least one adult staff in addition to the driver shall be present if at least seven children provided care by the center are transported.

g. Any child care center-sponsored program activity involving five or more children conducted away from the licensed facility shall provide a minimum of one additional staff over the required staff ratio for the protection of the children.

h. For a period of two hours or less at the beginning or end of the center's hours of operation, one staff may care for six children or less, provided no more than two of the children are under the age of two years.

i. For centers or preschools serving school-age children, the ratio for school-age children may be exceeded for a period of no more than four hours during a day when school classes start late or are dismissed early due to inclement weather or structural damage provided the children are already enrolled at the center and the center does not exceed the licensed capacity.

441—109.9(237A) Records.

109.9(1) *Personnel records.* The center shall maintain personnel information sufficient to ensure that persons employed in the center meet minimum staff and training requirements and do not pose any threat to the health, safety, or well-being of the children. Each employee's file shall contain, at a minimum, the following:

a. A statement signed by each individual indicating whether or not the individual has any conviction of violating any law in any state or has any record of founded child abuse or dependent adult abuse in any state.

b. Copies of all records checks kept in accordance with state and federal law regarding confidentiality of records checks. These records shall include:

(1) A copy of Form 595-1396, DHS Criminal History Record Check Form B, or any other permission form approved by the department of public safety for conducting an Iowa or national criminal history record check.

(2) A copy of Form 470-0643, Request for Child Abuse Information, when applicable.

(3) Copies of the results of Iowa records checks conducted through the SING for review by the department upon request.

(4) Copies of national criminal history check results.

(5) Any department-issued documents sent to the center related to a records check, regardless of findings.

c. Reserved.

d. A physical examination report. Personnel shall have good health as evidenced by a preemployment examination, including testing for communicable diseases which shall include testing for tuberculosis, performed within six months prior to beginning employment by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner and repeated at least every three years after initial employment.

e. Documentation showing the minimum staff training requirements as outlined at rule 441—109.7(237A) are met, including current certifications in first aid and cardiopulmonary resuscitation (CPR) and Iowa's training for the mandatory reporting of child abuse.

f. A photocopy of a valid driver's license if the staff will be involved in the transportation of children.

109.9(2) *Child's file.* Centers shall maintain sufficient information in a file for each child, which shall be updated at least annually or when the parent notifies the center of a change or the center becomes aware of a change, to ensure that:

a. A parent or an emergency contact authorized by the parent can be contacted at any time the child is in the care of the center.

b. Appropriate emergency medical and dental services can be secured for the child while in the center's care.

c. Information is available in the center regarding the specific health and medical needs of a child, including information regarding any professionally prescribed treatment. Information shall include a physical examination report as required at subrule 109.10(1). For a center serving school-age children that operates in the same school facility in which the child attends school, documentation shall include a statement signed by the parent that the immunization information is available in the school file.

d. A child is released only to authorized persons.

e. Documentation of injuries, accidents, or other incidents involving the child is maintained.

f. Parent authorization is obtained for a child to attend center-sponsored field trips and non-center activities. If parental authorization is obtained on an authorization form inclusive of all children participating in the activity, the authorization form shall be kept on file at the center.

109.9(3) *Immunization certificates.* Signed and dated Iowa immunization certificates, provided by the state department of public health, shall be on file for each child enrolled as prescribed by the department of public health at 641—Chapter 7.

109.9(4) *Daily activities.* For each child under two years of age, the center shall make a daily written record. At the end of the child's day at the center, the daily written record shall be provided verbally or in writing to the parent or the person who removes the child from the center. The record shall contain information on each of these areas:

a. The time periods in which the child has slept.

b. The amount of food consumed and the times at which the child has eaten.

c. The time of and any irregularities in the child's elimination patterns.

d. The general disposition of the child.

e. A general summary of the activities in which the child participated.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10]

441—109.10(237A) Health and safety policies. The child care center shall establish definite health policies, including the criteria for excluding a sick child from the center. The policies shall be consistent with the recommendations of the National Health and Safety Performance Standards and shall include, but are not limited to:

109.10(1) *Physical examination report.*

a. Preschool-age children. For each child five years of age and younger not enrolled in kindergarten, the child care center shall require an admission physical examination report, submitted within 30 days from the date of admission, signed by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner. The date of the physical examination shall be no more than 12 months prior to the first day of attendance at the center. The written report shall include past health history, status of present health including allergies, medications, and acute or chronic conditions, and recommendations for continued care when necessary. Annually thereafter, a statement of health condition, signed by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner, shall be submitted that includes any change in functioning, allergies, medications, or acute or chronic conditions.

b. School-age children. For each child five years of age and older and enrolled in school, the child care center shall require, prior to admission, a statement of health status signed by the parent or legal guardian that certifies that the child is free of communicable disease and that specifies any allergies, medications, or acute or chronic conditions. The statement from the parent shall be submitted annually thereafter.

c. Religious exemption. Nothing in this rule shall be construed to require medical treatment or immunization for staff or the child of any person who is a member of a church or religious organization which has guidelines governing medical treatment for disease that are contrary to these rules. In these instances, an official statement from the organization shall be incorporated in the personnel or child's file.

109.10(2) *Medical and dental emergencies.* The center shall have sufficient information and authorization to meet the medical and dental emergencies of children. The center shall have written procedures for medical and dental emergencies and shall ensure, through orientation and training, that all staff are knowledgeable of and able to implement the procedures.

109.10(3) *Medications.* The center shall have written procedures for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications, including the following:

a. All medications shall be stored in their original containers, with accompanying physician or pharmacist's directions and label intact and stored so they are inaccessible to children and the public. Nonprescription medications shall be labeled with the child's name.

b. For every day an authorization for medication is in effect and the child is in attendance, there shall be a notation of administration including the name of the medicine, date, time, dosage given or applied, and the initials of the person administering the medication or the reason the medication was not given.

c. 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.

109.10(4) *Daily contact.* Each child shall have direct contact with a staff person upon arrival for early detection of apparent illness, communicable disease, or unusual condition or behavior which may adversely affect the child or the group. The center shall post notice at the main entrance to the center where it is visible to parents and the public of exposure of a child receiving care by the center to a communicable disease, the symptoms, and the period of communicability. If the center is located in a building used for other purposes and shares the main entrance to the building, the notice shall be conspicuously posted in the center in an area that is frequented daily by parents or the public.

109.10(5) *Infectious disease control.* Centers shall establish policies and procedures related to infectious disease control and the use of universal precautions with the handling of any bodily excrement or discharge, including blood and breast milk. Soiled diapers shall be stored in containers separate from other waste.

109.10(6) *Quiet area for ill or injured.* The center shall provide a quiet area under supervision for a child who appears to be ill or injured. The parents or a designated person shall be notified of the child's status in the event of a serious illness or emergency.

109.10(7) *Staff hand washing.* The center shall ensure that staff demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease. All staff shall wash their hands at the following times:

a. Upon arrival at the center.

b. Immediately before eating or participating in any food service activity.

c. After diapering a child.

d. Before leaving the rest room either with a child or by themselves.

e. Before and after administering nonemergency first aid to a child if gloves are not worn.

f. After handling animals and cleaning cages.

109.10(8) *Children's hand washing.* The center shall ensure that staff assist children in personal hygiene sufficient to prevent or minimize the transmission of illness or disease. For each infant or child with a disability, a separate cloth for washing and one for rinsing may be used in place of running water. Children's hands shall be washed at the following times:

a. Immediately before eating or participating in any food service activity.

b. After using the rest room or being diapered.

c. After handling animals.

109.10(9) *First-aid kit.* The center shall ensure that a clearly labeled first-aid kit is available and easily accessible to staff at all times whenever children are in the center, in the outdoor play area, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

109.10(10) *Recording incidents.* Incidents involving a child, including minor injuries, minor changes in health status, or behavioral concerns, shall be reported to the parent on the day of the incident. Incidents resulting in an injury to a child shall be reported to the parent on the day of the incident. Incidents resulting in a serious injury to a child or significant change in health status shall be reported immediately to the parent. A written report shall be provided to the parent or person authorized to remove the child from the center. The written report shall be prepared by the staff member who observed the incident and a copy shall be retained in the child's file.

109.10(11) *Smoking.* Smoking and the use of tobacco products shall be prohibited at all times in the center and in every vehicle used to transport children. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during hours of operation of the center. Nonsmoking signs shall be posted at every entrance of the child care center and in every vehicle used to transport children. All signs shall include:

a. The telephone number for reporting complaints, and

b. The Internet address of the department of public health (www.iowasmokefreeair.gov).

109.10(12) *Transportation.* As outlined in Iowa Code section 321.446, all children transported in a motor vehicle subject to registration, except a bus, shall be individually secured by a safety belt, safety seat, or harness in accordance with federal motor vehicle safety standards and the manufacturer's instructions.

a. Children under the age of 6 shall be secured during transit in a federally approved child restraint system. Children under 1 year of age and weighing less than 20 pounds shall be secured during transit in a rear-facing child restraint system.

b. Children under the age of 12 shall not be located in the front seating section of the vehicle.

c. Drivers of vehicles shall possess a valid driver's license and shall not operate a vehicle while under the influence of alcohol, illegal drugs, prescription or nonprescription drugs that could impair the drivers' ability to operate a motor vehicle.

d. Vehicles that are owned or leased by the center shall receive regular maintenance and inspection according to manufacturer-recommended guidelines for vehicle and tire maintenance and inspection.

109.10(13) *Field trip emergency numbers.* Emergency telephone numbers for each child shall be taken by staff when transporting children to and from school and on field trips and non-center-sponsored activities away from the premises.

109.10(14) *Pets.* Animals kept on site shall be in good health with no evidence of disease, be of such disposition as to not pose a safety threat to children, and be maintained in a clean and sanitary manner. Documentation of current vaccinations shall be available for all cats and dogs. No ferrets, reptiles, including turtles, or birds of the parrot family shall be kept on site. Pets shall not be allowed in kitchen or food preparation areas.

109.10(15) *Emergency plans.*

a. The center shall have written emergency plans for responding to fire, tornado, flood (if area is susceptible to flood), intruders within the center, intoxicated parents and lost or abducted children. In addition, the center shall have guidelines for responding or evacuating in case of blizzards, power failures, bomb threats, chemical spills, earthquakes, or other disasters that could create structural damage to the center or pose health hazards. If the center is located within a ten-mile radius of a nuclear power plant or research facility, the center shall also have plans for nuclear evacuations. Emergency plans shall include written procedures including plans for transporting children and notifying parents, emergency telephone numbers, diagrams, and specific considerations for immobile children.

b. Emergency instructions, telephone numbers, and diagrams for fire, tornado, and flood (if area is susceptible to floods) shall be visibly posted by all program and outdoor exits. Emergency plan procedures shall be practiced and documented at least once a month for fire and for tornado. Records on the practice of fire and tornado drills shall be maintained for the current and previous year.

c. The center shall develop procedures for annual staff training on these emergency plans and shall include information on responding to fire, tornadoes, intruders, intoxicated parents and lost or abducted children in the orientation provided to new employees.

d. The center shall conduct a daily check to ensure that all exits are unobstructed.

109.10(16) *Supervision and access.*

a. The center director and on-site supervisor shall ensure that each staff member, substitute, or volunteer knows the number and names of children assigned to that staff member, substitute, or volunteer for care. Assigned staff, substitutes, and volunteers shall provide careful supervision.

b. Any person in the center who is not an owner, staff member, substitute, or volunteer who has a record check and department approval to be involved with child care shall not have unrestricted access to children for whom that person is not the parent, guardian, or custodian.

c. Persons who are exempt from the record check process are granted access in accordance with 109.6(6)*"a"*(2) unless the provisions of paragraph 109.10(16)*"d"* apply.

d. A sex offender who has been convicted of a sex offense against a minor and who is required to register with the Iowa sex offender registry under the provisions contained in Iowa Code chapter 692A shall not operate, manage, be employed by, or act as a contractor or volunteer at a child care center.

The sex offender also shall not be present upon the property of a child care center without the written permission of the center director, except for the time reasonably necessary to transport the offender's own minor child or ward to and from the center.

(1) Written permission shall include the conditions under which the sex offender may be present, including:

1. The precise location in the center where the sex offender may be present;
2. The reason for the sex offender's presence at the facility;
3. The duration of the sex offender's presence;
4. Description of the supervision that the center staff will provide the sex offender to ensure that no child is alone with the sex offender.

(2) Before giving written permission, the center director shall consult with the center licensing consultant. The written permission shall be signed and dated by the center director and the sex offender and kept on file for review by the center licensing consultant.

[**ARC 8650B**, IAB 4/7/10, effective 6/1/10]

441—109.11(237A) Physical facilities.

109.11(1) *Room size.* The program room size shall be a minimum of 80 square feet of useable floor space or sufficient floor space to provide 35 square feet of useable floor space per child. In rooms where floor space occupied by cribs is counted as useable floor space, there shall be 40 square feet of floor space per child. Kitchens, bathrooms, halls, lobby areas, storage areas and other areas of the center not designed as activity space for children shall not be used as regular program space or counted as useable floor space.

109.11(2) *Infants' area.* An area shall be provided properly and safely equipped for the use of infants and free from the intrusion of children two years of age and older. Children over 18 months of age may be grouped outside this area if appropriate to the developmental needs of the child. Upon the recommendation of a child's physician or the area education agency serving the child, a child who is two years of age or older with a disability that results in significant developmental delays in physical and cognitive functioning who does not pose a threat to the safety of the infants may, if appropriate and for a limited time approved by the department, remain in the infant area.

109.11(3) *Facility requirements.*

a. The center shall ensure that:

(1) The facility and premises are sanitary, safe and hazard-free.

(2) Adequate indoor and outdoor program space that is adjacent to the center is provided. Centers shall have a safe outdoor program area with at least sufficient square footage to accommodate 30 percent of the enrollment capacity at any one time at 75 square feet per child. The outdoor area shall include safe play equipment and an area of shade.

(3) Sufficient program space is provided for dining to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures.

(4) Sufficient lighting shall be provided to allow children to adequately perform developmental tasks without eye strain.

(5) Sufficient ventilation is provided to maintain adequate indoor air quality.

(6) Sufficient heating is provided to allow children to perform tasks comfortably without excessive clothing.

(7) Sufficient cooling is provided to allow children to perform tasks without being excessively warm or subject to heat exposure.

(8) Sufficient bathroom and diapering facilities are provided to attend immediately to children's toileting needs and maintained to reduce the transmission of disease.

(9) Equipment, including kitchen appliances, placed in a program area is maintained so as not to result in burns, shock or injury to children.

(10) Sanitation and safety procedures for the center are developed and implemented to reduce the risk of injury or harm to children and reduce the transmission of disease.

b. Approval may be given by the department to waive the outdoor space requirement for programs of three hours or less, provided there is suitable substitute space and equipment available.

c. Approval may be given by the department for centers operating in a densely developed area to use alternative outdoor play areas in lieu of adjacent outdoor play areas.

d. The director or designated person shall complete and keep a record of at least monthly inspections of the outdoor recreation area and equipment for the purpose of assessing and rectifying potential safety hazards. If the outdoor play area is not used for a period of time due to inclement weather conditions, the center shall document the reasons why the monthly inspection did not occur and shall complete and document an inspection prior to resuming use of the area.

e. Centers that operate in a public school building, including before and after school programs and summer programs serving school-age children, may receive limited exemption from a facility requirement at subrule 109.11(3), particularly relating to ventilation and bathroom facilities, if complying with the requirement would require a structural or mechanical change to the school building. Centers shall ensure that the space occupied by the center is sanitary, safe, and hazard-free and shall conduct monthly playground inspections or provide documentation that one has been completed by the public school personnel.

109.11(4) *Bathroom facilities.* At least one functioning toilet and one sink for each 15 children shall be provided in a room with natural or artificial ventilation. Training seats or chairs may be used for children under two years of age. New construction after November 1, 1995, shall provide for at least one sink in the same area as the toilet and, for centers serving children two weeks to two years of age, shall provide for at least one sink in the central diapering area. At least one sink shall be provided in program rooms for infants and toddlers or in an adjacent area other than the kitchen. New construction after April 1, 1998, shall have at least one sink provided in the program rooms for infants and toddlers.

109.11(5) *Telephone.* A working nonpay telephone shall be available in the center with emergency telephone numbers for police or 911, fire, ambulance, and poison information center posted adjacent to the telephone. The street address and telephone number of the center shall be included in the posting. A separate file or listing of emergency telephone numbers for each child shall be maintained near the telephone.

109.11(6) *Kitchen appliances and microwaves.* Gas or electric ranges or ovens shall not be placed in the program area. If kitchen appliances are maintained in the program area for food preparation activities, the area shall be sectioned off and shall not be counted as useable floor space for room size. Centers using microwave ovens for warming infant bottles or infant food shall ensure that the formula or food item is not served immediately to the child after being removed from the microwave. The infant bottle shall be shaken or food stirred and the formula or food item tested by the caregiver before being fed to the infant. Breast milk shall not be warmed in a microwave.

109.11(7) *Environmental hazards.*

a. Within one year of being issued an initial or renewal license, centers operating in facilities built prior to 1960 shall conduct a visual assessment for lead hazards that exist in the form of peeling or chipping paint. If the presence of peeling or chipping paint is found, the paint shall be presumed to be lead-based paint unless a certified inspector as defined in department of public health rules at 641—Chapter 70 determines that it is not lead-based paint. If the presence of peeling or chipping paint is found, interim controls using safe work methods as defined by the state department of public health shall be accomplished prior to a full license being issued.

b. Within one year of being issued an initial or renewal license, centers operating in facilities that are at ground level, use a basement area as program space, or have a basement beneath the program area shall have radon testing performed as prescribed by the state department of public health at 641—Chapter 43. Testing shall be required if test kits are available from the local health department or the Iowa Radon Coalition. Retesting shall be accomplished at least every two years from the date of the initial measurement if test kits are available from the local health department or the Iowa Radon Coalition. If testing determines confirmed radon gas levels in excess of 4.0 picocurie per liter, a plan using radon mitigation procedures established by the state department of public health shall be developed with and approved by the state department of public health prior to a full license being issued.

c. To reduce the risk of carbon monoxide poisoning, all centers shall, on an annual basis prior to the heating season, have a professional inspect all fuel-burning appliances, including oil and gas furnaces, gas water heaters, gas ranges and ovens, and gas dryers, to ensure the appliances are in good working order with proper ventilation. All centers shall install one carbon monoxide detector on each floor of the center that is listed with Underwriters Laboratory (UL) as conforming to UL Standard 2034.

d. Centers that operate before and after school programs and summer-only programs that serve only school-age children and that operate in a public school building are exempted from testing for lead, radon, and carbon monoxide.

441—109.12(237A) Activity program requirements.

109.12(1) *Activities.* The center shall have a written curriculum or program structure that uses developmentally appropriate practices and a written program of activities planned according to the developmental level of the children. The center shall post a schedule of the program in a visible place. The child care program shall complement but not duplicate the school curriculum. The program shall be designed to provide children with:

a. A curriculum or program of activities that promotes self-esteem and positive self-image; social interaction; self-expression and communication skills; creative expression; and problem-solving skills.

b. A balance of active and quiet activities; individual and group activities; indoor and outdoor activities; and staff-initiated and child-initiated activities.

c. Activities which promote both gross and fine motor development.

d. Experiences in harmony with the ethnic and cultural backgrounds of the children.

e. A supervised nap or quiet time for all children under the age of six not enrolled in school who are present at the center for five or more hours.

109.12(2) *Discipline.* The center shall have a written policy on the discipline of children which provides for positive guidance, with direction for resolving conflict and the setting of well-defined limits. The written policy shall be provided to staff at the start of employment and to parents at time of admission. The center shall not use as a form of discipline:

a. Corporal punishment including spanking, shaking, and slapping.

b. Punishment which is humiliating or frightening or which causes pain or discomfort to the child. Children shall never be locked in a room, closet, box or other device. Mechanical restraints shall never be used as a form of discipline. When restraints are part of a treatment plan for a child with a disability authorized by the parent and a psychologist or psychiatrist, staff shall receive training on the safe and appropriate use of the restraint.

c. Punishment or threat of punishment associated with a child's illness, lack of progress in toilet training, or in connection with food or rest.

d. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

109.12(3) *Policies for children requiring special accommodations.* Reasonable accommodations, based on the special needs of the child, shall be made in providing care to a child with a disability. Accommodation can be a specific treatment prescribed by a professional or a parent, or a modification of equipment, or removal of physical barriers. The accommodation shall be recorded in the child's file.

109.12(4) *Play equipment, materials and furniture.* The center shall provide sufficient and safe indoor play equipment, materials, and furniture that conform with the standards or recommendations of the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products. Play equipment, materials, and furniture shall meet the developmental, activity, and special needs of the children.

Rooms shall be arranged so as not to obstruct the direct observation of children by staff. Individual covered mats, beds, or cots and appropriate bedding shall be provided for all children who nap. The center shall develop procedures to ensure that all equipment and materials are maintained in a sanitary manner. Sufficient spacing shall be maintained between equipment to reduce the transmission of disease, to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures. The center shall provide sufficient

toilet articles for each child for hand washing. Parents may provide items for oral hygiene (if appropriate to the developmental age and needs of the child). The center shall ensure that sanitary procedures are followed for use and storage of the articles.

109.12(5) *Infant environment.* A child care center serving children two weeks to two years old must provide an environment which protects the children from physical harm, but is not so restrictive as to inhibit physical, intellectual, emotional, and social development.

a. Stimulation shall be provided to each child through being held, rocked, played with and talked with throughout the time care is provided. Insofar as possible, the same adult should provide complete care for the same child.

b. Each infant and toddler shall be diapered in a sanitary manner as frequently as needed at a central diapering area. Diapering, sanitation, and hand-washing procedures shall be posted and implemented in every diapering area. There shall be at least one changing table for every 15 infants.

c. Highchairs or hook-on seats shall be equipped with a safety strap which shall be engaged when the chair is in use and shall be constructed so the chair will not topple.

d. Safe, washable toys, large enough so they cannot be swallowed and with no removable parts, shall be provided. All hard-surface toys used by children shall be sanitized daily.

e. Children under the age of one year shall be placed on their backs when sleeping unless otherwise authorized by a parent or physician. A crib or criblike furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards or recommendations from the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products shall be provided for each child under two years of age if developmentally appropriate. Crib railings shall be fully raised and secured when the child is in the crib. A crib or criblike furniture shall be provided for the number of children present at any one time. The center shall develop procedures for maintaining all cribs or criblike furniture and bedding in a clean and sanitary manner. There shall be no restraining devices of any type used in cribs.

f. When playpens are provided, no more than one child shall be placed in one at any time.

g. Infant walkers shall not be used.

h. For programs operating five hours or less on a daily basis, the center shall have a sufficient number of cribs or criblike furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards from the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products for children who may nap during the time in attendance. Cribs or criblike furniture shall be used by only one child at a time and shall be maintained in a clean and sanitary manner.

441—109.13(237A) Extended evening care. A center providing extended evening care shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter, with the additional requirements set forth below.

109.13(1) *Facility requirements.*

a. The center shall ensure that sufficient cribs, beds, cots and bedding are provided appropriate to the child's age and that sufficient furniture, lighting, and activity materials are available for the children. Equipment and materials shall be maintained in a safe and sanitary manner.

b. The center shall ensure that a separate space is maintained for school-age boys and girls to provide privacy during bathroom and bedtime activities. Bathroom doors used by children shall be nonlockable.

c. The center shall ensure that parents have provided the personal effects needed to meet their child's personal hygiene and prepare for sleep. The center shall supplement those items needed for personal hygiene which the parent does not provide. The center shall obtain written information from the parent regarding the child's snacking, toileting, personal hygiene and bedtime routines.

109.13(2) *Activities.*

a. Evening activities shall be primarily self-selected by the child.

b. Every child-occupied room except those rooms used only by school-age children for sleeping shall have adult supervision present in the room. Staff counted for purposes of meeting child-to-staff

ratios shall be present and awake at all times. In rooms where only school-age children are sleeping, visual monitoring equipment may be used. If a visual monitor is used, the monitoring must allow for all children to be visible at all times. Staff shall be present in the room with the monitor and shall enter the room used for sleeping to conduct a check of the children every 15 minutes.

441—109.14(237A) Get-well center. A get-well center shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the additional requirements and exceptions set forth below.

109.14(1) *Staff requirements.*

a. The center shall have a medical advisor for the center's health policy. The medical advisor shall be a medical doctor or a doctor of osteopathy currently in pediatrics or family practice.

b. A center shall have a licensed LPN or RN on duty at all times that children are present. If the nurse on duty is an LPN, the medical advisor or an RN shall be available in the proximate area as defined in state board of nursing rules at 655—6.1(152).

109.14(2) *Health policies.*

a. The center shall have a written health policy, consistent with the National Health and Safety Performance Standards, approved and signed by the owner or the chair of the board and by the medical advisor before the center can begin operations. Changes in the health policy shall be approved by the medical advisor and submitted in writing to the department. A written summary of the health policy shall be given to the parent when a child is enrolled in the center. The center's health policy at a minimum shall address procedures in the following areas:

(1) Medical consultation, medical emergencies, triage policies, storage and administration of medications, dietary considerations, sanitation and infection control, categorization of illness, length of enrollment periods, exclusion policy, and employee health policy.

(2) Reportable disease policies as required by the state department of public health.

b. The child shall be given a brief evaluation by an LPN or RN upon each arrival at the center.

c. The parent shall receive a brief written summary when the child is picked up at the end of the day. The summary must include:

(1) Admitting symptoms.

(2) Medications administered and time they were administered.

(3) Nutritional intake.

(4) Rest periods.

(5) Output.

(6) Temperature.

109.14(3) *Exceptions.* The following exceptions to 441—Chapter 109 shall be applied to get-well centers:

a. A center shall maintain a minimum staff ratio of one-to-four for infants and one-to-five for children over the age of two.

b. All staff that have contact with children shall have a minimum of 17 clock hours of special training in caring for mildly ill children. Current certification of the training shall be contained in the personnel files. Special training shall be department-approved and include the following:

(1) Four hours' training in infant and child cardiopulmonary resuscitation (CPR), four hours' training in pediatric first aid, and one hour of training in infection control within the first month of employment.

(2) Six hours' training in care of ill children, and two hours' training in child abuse identification and reporting within the first six months of employment and every five years thereafter.

c. There shall be 40 square feet of program space per child.

d. There shall be a sink with hot and cold running water in every child-occupied room.

e. Outdoor space may be waived with the approval of the department if the program is in an area adjacent to the pediatrics unit of a hospital.

f. Grouping of children shall be allowed by categorization of illness or by transmission route without regard to age, and shall be in separate rooms with full walls and doors.

441—109.15(237A) Food services. Centers participating in the USDA Child and Adult Care Food Program (CACFP) may have requirements that differ from those outlined in this rule in obtaining CACFP reimbursement and shall consult with a state CACFP consultant.

109.15(1) *Nutritionally balanced meals or snacks.* The center shall serve each child a full, nutritionally balanced meal or snack as defined by the USDA Child and Adult Care Food Program (CACFP) guidelines and shall ensure that staff provide supervision at the table during snacks and meals. Children remaining at the center two hours or longer shall be offered food at intervals of not less than two hours or more than three hours apart unless the child is asleep.

109.15(2) *Menu planning.* The center shall follow the minimum CACFP menu patterns for meals and snacks and serving sizes for children aged infant to 13 years. Menus shall be planned at least one week in advance, made available to parents, and kept on file at the center. Substitutions in the menu, including substitutions made for infants, shall be noted and kept on file. Foods with a high incident rate of causing choking in young children shall be avoided or modified. Provisions of this subrule notwithstanding, exceptions shall be allowed for special diets because of medical reasons in accordance with the child's needs and written instructions of a licensed physician or health care provider.

109.15(3) *Feeding of children under two years of age.*

a. All children under 12 months of age shall be fed on demand, unless the parent provides other written instructions. Meals and snacks provided by the center shall follow the CACFP infant menu patterns. Foods shall be appropriate for the infant's nutritional requirements and eating abilities. Menu patterns may be modified according to written instructions from the parent, physician or health care provider. Special formulas prescribed by a physician or health care provider shall be given to a child who has a feeding problem.

b. All children under six months of age shall be held or placed in a sitting-up position sufficient to prevent aspiration during feeding. No bottles shall be propped for children of any age. A child shall not be placed in a crib with a bottle or left sleeping with a bottle. Spoon feeding shall be adapted to the developmental capabilities of the child.

c. Single-service, ready-to-feed formulas, concentrated or powdered formula following the manufacturer's instructions or breast milk shall be used for children 12 months of age and younger unless otherwise ordered by a parent or physician.

d. Whole milk for children under age two who are not on formula or breast milk unless otherwise directed by a physician.

e. Cleaned and sanitized bottles and nipples shall be used for bottles prepared on site. Prepared bottles shall be kept under refrigeration when not in use.

109.15(4) *Food brought from home.*

a. The center shall establish policies regarding food brought from home for children under five years of age who are not enrolled in school. A copy of the written policy shall be given to the parent at admission. Food brought from home for children under five years of age who are not enrolled in school shall be monitored and supplemented if necessary to ensure CACFP guidelines are maintained.

b. The center may not restrict a parent from providing meals brought from home for school-age children or apply nutritional standards to the meals.

c. Perishable foods brought from home shall be maintained to avoid contamination or spoilage.

d. Snacks that may not meet CACFP nutrition guidelines may be provided by parents for special occasions such as birthdays or holidays.

109.15(5) *Food preparation, storage, and sanitation.* Centers shall ensure that food preparation and storage procedures are consistent with the recommendations of the National Health and Safety Performance Standards and provide:

a. Sufficient refrigeration appropriate to the perishable food to prevent spoilage or the growth of bacteria.

b. Sanitary and safe methods in food preparation, serving, and storage sufficient to prevent the transmission of disease, infestation of insects and rodents, and the spoilage of food. Staff preparing food who have injuries on their hands shall wear protective gloves. Staff serving food shall have clean hands or wear protective gloves and use clean serving utensils.

c. Sanitary methods for dish-washing techniques sufficient to prevent the transmission of disease.

d. Sanitary methods for garbage disposal sufficient to prevent the transmission of disease and infestation of insects and rodents.

109.15(6) *Water supply.* The center shall ensure that suitable water and sanitary drinking facilities are available and accessible to children. Centers that serve infants and toddlers shall provide individual cups for drinking in addition to drinking fountains that may be available in the center.

a. Private water supplies shall be of satisfactory bacteriological quality as shown by an annual laboratory analysis. Water for the analysis shall be drawn between May 1 and June 30 of each year. When the center provides care for children under two years of age, a nitrate analysis shall also be obtained.

b. When public or private water supplies are determined unsuitable for drinking, commercially bottled water certified as chemically and bacteriologically potable or water treated through a process approved by the health department or designee shall be provided.

These rules are intended to implement Iowa Code section 232.69 and chapter 237A.

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CHAPTER 124
DISCIPLINE FOR HEARING AID DISPENSERS
[Prior to 5/29/02, see 645—120.11(272C)]

645—124.1(154A,272C) Definitions.

"Board" means the board of hearing aid dispensers.

"Discipline" means any sanction the board may impose upon licensees.

"Licensee" means a person licensed to practice as a hearing aid dispenser in Iowa.

645—124.2(154A,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in rule 645—124.3(154A,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

124.2(1) Failure to comply with the current Code of Ethics of the International Hearing Society. The board hereby adopts by reference the current Code of Ethics of the International Hearing Society, available at http://www.ihsinfo.org.

124.2(2) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, the following:

a. An intentional perversion of the truth in making application for a license to practice in this state;

b. False representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state; or

c. Attempting to file or filing with the board or the department of public health any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a license in this state.

124.2(3) Professional incompetence. Professional incompetence includes, but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice;

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other hearing aid dispensers in the state of Iowa acting in the same or similar circumstances;

c. A failure to exercise the degree of care which is ordinarily exercised by the average hearing aid dispenser acting in the same or similar circumstances;

d. Failure to conform to the minimal standard of acceptable and prevailing practice of licensed hearing aid dispensers in this state.

124.2(4) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of hearing aid dispensing or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

124.2(5) Advertising that hearing testing or hearing screening is for the purpose of detection or diagnosis of medical problems or medical screening for referral to a physician.

124.2(6) Failure to place all of the following in an advertisement relating to hearing aids:

a. Hearing aid dispenser's name.

b. Hearing aid dispenser's office address.

c. Hearing aid dispenser's telephone number.

124.2(7) Practice outside the scope of the profession.

124.2(8) The use of untruthful or improbable statements in advertisements. The use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation.

124.2(9) Except in cases of selling replacement hearing aids of the same make or model within one year of the original sale, a hearing aid shall not be sold without adequate diagnostic testing and evaluation using established procedures to assess hearing needs as defined in 645—Chapter 123. Instruments shall be calibrated to current standards at least annually or more often if necessary. The distributor shall keep with the instruments a certificate indicating the date of calibration.

124.2(10) Habitual intoxication or addiction to the use of drugs.

a. The inability of a licensee to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

b. The excessive use of drugs which may impair a licensee's ability to practice with reasonable skill or safety.

124.2(11) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

124.2(12) Falsification of client records.

124.2(13) Acceptance of any fee by fraud or misrepresentation.

124.2(14) Misappropriation of funds.

124.2(15) Negligence by the licensee in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care, including improper delegation of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession.

124.2(16) Conviction of a crime related to the profession or occupation of the licensee or the conviction of any crime that would affect the licensee's ability to practice within the profession, regardless of whether the judgment of conviction or sentence was deferred. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

124.2(17) Violation of a regulation, rule, or law of this state, another state, or the United States, which relates to the practice of hearing aid dispensing.

124.2(18) Revocation, suspension, or other disciplinary action taken by a licensing authority of this state, another state, territory or country; or failure of the licensee to report such action within 30 days of the final action by such licensing authority. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, such report shall be expunged from the records of the board.

124.2(19) Failure of a licensee or an applicant for licensure in this state to report any voluntary agreements restricting the individual's practice as a hearing aid dispenser in another state, district, territory or country.

124.2(20) Failure to notify the board of a criminal conviction within 30 days of the action, regardless of the jurisdiction where it occurred.

124.2(21) Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice claim or action.

124.2(22) Engaging in any conduct that subverts or attempts to subvert a board investigation.

124.2(23) Failure to comply with a subpoena issued by the board or failure to cooperate with an investigation of the board.

124.2(24) Failure to respond within 30 days of receipt of communication from the board which was sent by registered or certified mail.

124.2(25) Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order.

124.2(26) Failure to pay costs assessed in any disciplinary action.

124.2(27) Submission of a false report of continuing education or failure to submit the biennial report of continuing education.

124.2(28) Failure to report another licensee to the board for any violations listed in these rules, pursuant to Iowa Code section 272C.9.

124.2(29) Knowingly aiding, assisting, or advising a person to unlawfully practice as a hearing aid dispenser.

124.2(30) Failure to report a change of name or address within 30 days after the occurrence.

124.2(31) Representing oneself as a licensed hearing aid dispenser when one's license has been suspended or revoked, or when one's license is on inactive status.

124.2(32) Permitting another person to use the licensee's license for any purpose.

124.2(33) Permitting an unlicensed employee or person under the licensee's control to perform activities that require a license.

124.2(34) Unethical conduct. In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct may include, but is not limited to, the following:

a. Verbally or physically abusing a patient, client, or coworker.

b. Improper sexual contact with or making suggestive, lewd, lascivious or improper remarks or advances to a patient, client or coworker.

c. Betrayal of a professional confidence.

d. Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

e. Being adjudged mentally incompetent by a court of competent jurisdiction.

124.2(35) Repeated failure to comply with standard precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

124.2(36) Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.

[**ARC 9424B**, IAB 3/9/11, effective 4/13/11 (See Delay note at end of chapter); **ARC 0032C**, IAB 3/7/12, effective 4/11/12]

645—124.3(154A,272C) Method of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revocation of license.
2. Suspension of license until further order of the board or for a specific period.
3. Prohibit permanently, until further order of the board, or for a specific period the licensee's engaging in specified procedures, methods, or acts.
4. Probation.
5. Require additional education or training.
6. Require a reexamination.
7. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
8. Impose civil penalties not to exceed $1000.
9. Issue a citation and warning.
10. Such other sanctions allowed by law as may be appropriate.

645—124.4(272C) Discretion of board. The following factors may be considered by the board in determining the nature and severity of the disciplinary sanction to be imposed:

1. The relative serious nature of the violation as it relates to ensuring a high standard of professional care for the citizens of this state;
2. The facts of the particular violation;
3. Any extenuating facts or other countervailing considerations;
4. The number of prior violations or complaints;
5. The seriousness of prior violations or complaints;
6. Whether remedial action has been taken; and
7. Such other factors as may reflect upon the competency, ethical standards, and professional conduct of the licensee.

645—124.5(154A) Order for mental, physical, or clinical competency examination or alcohol or drug screening. Rescinded IAB 1/14/09, effective 2/18/09.

These rules are intended to implement Iowa Code chapters 147, 154A and 272C.

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[1] April 13, 2011, effective date of 124.2(6) delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

REGENTS BOARD[681]

[Prior to 4/20/88, Regents, Board of [720]]

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CHAPTER 1
ADMISSION RULES COMMON TO THE THREE STATE UNIVERSITIES

[Prior to 4/20/88, Regents, Board of[720]]

Preamble: The state board of regents has adopted the following requirements governing admission of students to the three state universities.

Each university is expected to describe in its catalog the requirements and other information necessary to make the admission process operate within the framework of these requirements.

Amendments and changes in these requirements normally are proposed by the universities to the regent committee on educational relations which examines the proposals and makes specific recommendations through the interinstitutional committee on educational coordination to the state board of regents which is empowered by law to establish the admission requirements.

681—1.1(262) Admission of undergraduate students directly from high school. Students desiring admission to the University of Iowa, Iowa State University, or the University of Northern Iowa must meet the requirements in this rule and also any special requirements for the curriculum, school, or college of their choice.

1.1(1) Application. Applicants must submit a formal application for admission, together with the appropriate application fee as approved by the state board of regents pursuant to Iowa Code subsection 262.9(18) and detailed in rule 681—1.7(262), and have their secondary school provide a transcript of their academic record, including credits and grades, rank in class, and certification of graduation. Applicants must also submit SAT Reasoning Test or ACT scores. Applicants whose primary language is not English must also meet the English language proficiency requirement specified by each university. Applicants may be required to submit additional information or data to support their applications.

1.1(2) Admission criteria.

a. Effective for students who seek admission prior to fall 2009. Graduates of approved Iowa high schools who have the subject matter background required by each university and who rank in the upper one-half of their graduating class will be admitted to any regent university. Applicants who are not in the upper one-half of their graduating class may, after an individual review of their academic and test records, and at the discretion of the admissions officers:

(1) Be admitted unconditionally,

(2) Be admitted conditionally,

(3) Be required to enroll for a tryout period during a preceding summer session, or

(4) Be denied admission.

b. Effective for students who seek admission in fall 2009 and thereafter.

(1) Decisions on admission to a regent university are based on the following four factors: performance on standardized tests (SAT Reasoning Test or ACT); high school grade point average (GPA); high school percentile rank in class; and number of high school courses completed in the core subject areas. These factors are used in the following equation to calculate a regent admission index (RAI):

RAI = (2 × ACT composite score) + (1 × high school rank expressed as a percentile) + (20 × high school grade point average) + (5 × number of high school courses completed in the core subject areas)

NOTE: For purposes of calculating the regent admission index, the ACT composite score has a top value of 36 (SAT scores will be converted to ACT composite equivalents); high school rank is expressed as a percentile with 99 percent as the top value; high school GPA is expressed in a four-point scale; and number of high school courses completed in the core subject areas is expressed in terms of years or fractions of years of study.

(2) Graduates of approved Iowa high schools who have the subject matter background required by each university and who meet the regent admission index of 245 required for automatic admission will be admitted to any regent university. Applicants who do not meet the regent admission index of 245 for automatic admission or for whom a regent admission index cannot be calculated may, after an individual review of their academic and test records, and at the discretion of the admissions officers:

1. Be admitted unconditionally,
2. Be admitted conditionally,
3. Be required to enroll for a tryout period during a preceding summer session, or
4. Be denied admission.

1.1(3) Graduates of approved high schools in other states may be held to higher academic standards, but must meet at least the same requirements as graduates of Iowa high schools. The options for conditional admission or summer tryout enrollment may not necessarily be offered to these students.

1.1(4) Applicants who are graduates of nonapproved high schools will be considered for admission in a manner similar to applicants from approved high schools, but additional emphasis will be given to scores obtained on standardized examinations.

1.1(5) Applicants who are not high school graduates, but whose classes have graduated, may be considered for admission. These applicants will be required to submit all academic data to the extent that it exists and achieve scores on standardized examinations which will demonstrate that they are adequately prepared for academic study.

1.1(6) Early admission.

a. Students with superior academic records may be admitted, on an individual basis, for part-time university study while enrolled in high school or during the summers prior to high school graduation.

b. In rare situations, exceptional students may be admitted as full-time students to a regent university before completing high school. Early admission to a regent university is provided to serve persons whose academic achievement and personal and intellectual maturity clearly suggest readiness for collegiate level study. Each university will specify requirements and conditions for early admission.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.2(262) Admission of undergraduate students by transfer from other colleges. Students desiring admission to the University of Iowa, Iowa State University, or the University of Northern Iowa must meet the requirements in this rule and also any special requirements for the curriculum, school, or college of their choice.

Applicants must submit a formal application for admission, together with the appropriate application fee as approved by the state board of regents pursuant to Iowa Code subsection 262.9(18) and detailed in rule 681—1.7(262), and request that each college they have attended send an official transcript of record to the admissions office. High school academic records and standardized test results may also be required. The Test of English as a Foreign Language (TOEFL) is required of foreign students whose first language is not English.

1.2(1) Transfer applicants with a minimum of 24 semester hours of graded credit from regionally accredited colleges or universities, who have achieved for all college work previously attempted the grade point required by each university for specific programs, will be admitted. Higher academic standards may be required of students who are not residents of Iowa.

Applicants who have not maintained the grade point required by each university for specific programs or who are under academic suspension from the last college attended may, after a review of their academic and test records, and at the discretion of the admissions officers:

a. Be admitted unconditionally,
b. Be admitted conditionally,
c. Be required to enroll for a tryout period during a preceding summer session, or
d. Be denied admission.

1.2(2) Admission of students with fewer than 24 semester hours of college credit will be based on high school academic and standardized test records in addition to review of the college record.

1.2(3) Transfer applicants under disciplinary suspension will not be considered for admission until information concerning the reason for the suspension has been received from the college assigning the suspension. Applicants granted admission under these circumstances will be admitted on probation.

1.2(4) Transfer applicants from colleges and universities not regionally accredited will be considered for admission on an individual basis taking into account all available academic information.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.3(262) Transfer credit practices. The regent universities endorse the Joint Statement on Transfer and Award of Academic Credit approved in 1978 by the American Council on Education (ACE), the American Association of Collegiate Registrars and Admissions Officers (AACRAO), and the Council on Postsecondary Accreditation (COPA). The current issue of Transfer Credit Practices of Selected Educational Institutions, published by the American Association of Collegiate Registrars and Admissions Officers (AACRAO), and publications of the Council on Postsecondary Accreditation (COPA) are examples of references used by the universities in determining transfer credit. The acceptance and use of transfer credit is subject to limitations in accordance with the educational policies operative at each university.

1.3(1) *Students from regionally accredited colleges and universities.* Credit earned at regionally accredited colleges and universities is acceptable for transfer except that credit in courses determined by the receiving university to be of a remedial, vocational, or technical nature, or credit in courses or programs in which the institution granting the credit is not directly involved, may not be accepted, or may be accepted to a limited extent.

Of the coursework earned at a two-year college, students may apply up to one-half but no more than 65 hours of the credits required for a bachelor's degree toward that degree at a regent university. This policy becomes effective September 29, 1993.

1.3(2) *Students from colleges and universities which have candidate status.* Credit earned at colleges and universities which have become candidates for accreditation by a regional association is acceptable for transfer in a manner similar to that from regionally accredited colleges and universities if the credit is applicable to the bachelor's degree at the receiving university.

Credit earned at the junior and senior classification from an accredited two-year college which has received approval by a regional accrediting association for change to a four-year college may be accepted by a regent university.

1.3(3) *Students from colleges and universities not regionally accredited.* When students are admitted from colleges and universities not regionally accredited, they may validate portions or all of their transfer credit by satisfactory academic study in residence, or by examination. Each university will specify the amount of the transfer credit and the terms of the validation process at the time of admission.

In determining the acceptability of transfer credit from private colleges in Iowa which do not have regional accreditation, the regent committee on educational relations, upon request from the institutions, evaluates the nature and standards of the academic program, faculty, student records, library, and laboratories.

In determining the acceptability of transfer credit from colleges in states other than Iowa which are not regionally accredited, acceptance practices indicated in the current issue of Transfer Credit Practices of Selected Educational Institutions will be used as a guide. For institutions not listed in the publication, guidance is requested from the designated reporting institution of the appropriate state.

1.3(4) *Students from foreign colleges and universities.* Transfer credit from foreign educational institutions may be granted after a determination of the type of institution involved and after an evaluation of the content, level, and comparability of the study to courses and programs at the receiving university. Credit may be granted in specific courses, but is frequently assigned to general areas of study. Extensive use is made of professional journals and references which describe the education systems and programs of individual countries.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.4(262) Classification of residents and nonresidents for admission, tuition, and fee purposes.

1.4(1) *General.*

a. A person enrolling at one of the three state universities shall be classified as a resident or nonresident for admission, tuition, and fee purposes by the registrar or someone designated by the registrar. The decision shall be based upon information furnished by the student and other relevant information.

b. In determining resident or nonresident classification, the issue is essentially one of why the person is in the state of Iowa. If the person is in the state primarily for educational purposes, that person

will be considered a nonresident. For example, it may be possible that an individual could qualify as a resident of Iowa for such purposes as voting, or holding an Iowa driver's license, and not meet the residency requirements as established by the board of regents for admission, tuition, and fee purposes.

c. The registrar, or designated person, is authorized to require written documents, affidavits, verifications, or other evidence deemed necessary to determine why a student is in Iowa. The burden of establishing that a student is in Iowa for other than educational purposes is upon the student.

A student may be required to file any or all of the following:

(1) A statement from the student describing employment and expected sources of support;

(2) A statement from the student's employer;

(3) A statement from the student's parents verifying nonsupport and the fact that the student was not listed as a dependent on tax returns for the past year and will not be so listed in future years;

(4) A statement from the student's spouse related to sources of family support, length of residence in Iowa, and reasons for being in the state of Iowa;

(5) Supporting statements from persons who might be familiar with the family situation;

(6) Iowa state income tax return.

d. Applications for resident classification for a given semester or session are due no later than the fifteenth class day of that semester or session. Applications received after the fifteenth class day of that semester or session will be considered for the next semester or session. Appeals of any nonresident classification decision resulting from applications for resident classifications are due no later than midterm of that semester or session. Change of classification from nonresident to resident will not be made retroactive beyond the term in which application for resident classification is made.

e. A student who gives incorrect or misleading information to evade payment of nonresident fees shall be subject to serious disciplinary action and must also pay the nonresident fees for each term previously attended.

f. Review committee. These regulations shall be administered by the registrar or someone designated by the registrar. The decision of the registrar or designated person may be appealed to a university review committee. The decision of the review committee may be appealed to the state board of regents.

1.4(2) *Guidelines.*

a. The following general guidelines are used in determining the resident classification of a student for admission, tuition, and fee purposes:

(1) A financially dependent student whose parents move from Iowa after the student is enrolled remains a resident provided the student maintains continuous enrollment. A financially dependent student whose parents move from Iowa during the senior year of high school will be considered a resident provided the student has not established domicile in another state.

(2) In deciding why a person is in the state of Iowa, the person's domicile will be considered. A person who comes to Iowa from another state and enrolls in any institution of postsecondary education for a full program or substantially a full program shall be presumed to have come to Iowa primarily for educational reasons rather than to establish a domicile in Iowa.

(3) A student who was a former resident of Iowa may continue to be considered a resident provided absence from the state was for a period of less than 12 months and provided domicile is reestablished. If the absence from the state is for a period exceeding 12 months, a student may be considered a resident if evidence can be presented showing that the student has long-term ties to Iowa and reestablishes an Iowa domicile.

A person or the dependent of a person whose domicile is permanently established in Iowa, who has been classified as a resident for admission, tuition, and fee purposes, may continue to be classified as a resident so long as domicile is maintained, even though circumstances may require extended absence of the person from the state. It is required that a person who claims Iowa domicile while living in another state or country will provide proof of the continual Iowa domicile as evidence that the person:

1. Has not acquired a domicile in another state,
2. Has maintained a continuous voting record in Iowa, and
3. Has filed regular Iowa resident income tax returns during absence from the state.

(4) A student who moves to Iowa may be eligible for resident classification at the next registration following 12 consecutive months in the state provided the student is not enrolled as more than a half-time student (6 credits for an undergraduate or professional student, 5 credits for a graduate student) in any academic year term, is not enrolled for more than 4 credits in a summer term for any classification, and provides sufficient evidence of the establishment of an Iowa domicile.

(5) A student who has been a continuous student and whose parents move to Iowa may become a resident at the beginning of the next term provided the student is dependent upon the parents for a majority of financial assistance.

(6) A person who has been certified as a refugee or granted asylum by the appropriate agency of the United States who enrolls as a student at a university governed by the Iowa state board of regents may be accorded immediate resident status for admission, tuition, and fee purposes when the person:

1. Comes directly to the state of Iowa from a refugee facility or port of debarkation, or
2. Comes to the state of Iowa within a reasonable time and has not established domicile in another state.

Any refugee or individual granted asylum not meeting these standards will be presumed to be a nonresident for admission, tuition, and fee purposes and thus subject to the usual method of proof of establishment of Iowa residency.

(7) An alien who has immigrant status establishes Iowa residency in the same manner as a United States citizen.

(8) At the regent institutions, American Indians who have origins in any of the original people of North America and who maintain a cultural identification through tribal affiliation or community recognition with one or more of the tribes or nations connected historically with the present state of Iowa, including the Iowa, Kickapoo, Menominee, Miami, Missouri, Ojibwa (Chippewa), Omaha, Otoe, Ottawa (Odawa), Potawatomi, Sac and Fox (Sauk, Meskwaki), Sioux, and Winnebago (Ho Chunk), will be assessed Iowa resident tuition and fees.

b. Additional guidelines are used in determining the resident classification of a veteran, qualified military person, and dependent children and spouses of a veteran or qualified military person for purposes of admission and undergraduate tuition and mandatory fees:

(1) A person who is stationed on active duty at the Rock Island arsenal as a result of military orders, or the dependent child or spouse of such person, is entitled to resident status for purposes of undergraduate tuition and mandatory fees. However, if the arrival of the person under orders is subsequent to the beginning of the term in which the dependent child or spouse is first enrolled, nonresident fees will be charged in all cases for the dependent child or spouse until the beginning of the next term in which the dependent child or spouse is enrolled. If the qualified military person is transferred, deployed, or restationed while the person's spouse or dependent child is enrolled in an institution of higher education under the control of the board of regents, the spouse or dependent child shall continue to be classified as a resident under this subparagraph until the close of the fiscal year in which the spouse or dependent child is enrolled.

(2) A veteran who is domiciled or moves to the state of Iowa and who is eligible for benefits, or has exhausted benefits under the federal Post-9/11 Veterans Educational Assistance Act of 2008, is entitled to resident status for purposes of undergraduate tuition and mandatory fees. The dependent child or spouse of a veteran who meets these requirements is entitled to resident status for undergraduate tuition. However, if the arrival of the veteran in Iowa is subsequent to the beginning of the term in which the dependent child or spouse is first enrolled, nonresident fees will be charged in all cases for the dependent child or spouse until the beginning of the next term in which the dependent child or spouse is enrolled.

(3) A person who is moved into the state as the result of military or civil orders from the government for other than educational purposes, or the dependent child or spouse of such a person, is entitled to resident status. However, if the arrival of the person under orders is subsequent to the beginning of the term in which the dependent child or spouse is first enrolled, nonresident fees will be charged in all cases until the beginning of the next term in which the dependent child or spouse is enrolled. Legislation, effective July 1, 1977, requires that military personnel who claim residency in Iowa (home of record) will be required to file Iowa resident income tax returns.

1.4(3) *Facts.*

a. The following circumstances, although not necessarily conclusive, have probative value in support of a claim for resident classification:

(1) Reside in Iowa for 12 consecutive months, and be primarily engaged in activities other than those of a full-time student, immediately prior to the beginning of the term for which resident classification is sought.

(2) Reliance upon Iowa resources for financial support.

(3) Domicile in Iowa of persons legally responsible for the student.

(4) Former domicile in the state and maintenance of significant connections therein while absent.

(5) Acceptance of an offer of permanent employment in Iowa.

(6) Military orders, if for other than educational purposes.

(7) Other facts indicating the student's domicile will be considered by the universities in classifying the student.

b. The following circumstances, standing alone, do not constitute sufficient evidence of domicile to effect classification of a student as a resident under these regulations:

(1) Voting or registration for voting.

(2) Employment in any position normally filled by a student.

(3) The lease of living quarters.

(4) Admission to a licensed practicing profession in Iowa.

(5) Automobile registration.

(6) Public records, for example, birth and marriage records, Iowa driver's license.

(7) Continuous presence in Iowa during periods when not enrolled in school.

(8) Ownership of property in Iowa, or the payment of Iowa taxes.

This rule is intended to implement Iowa Code section 262.9(3).

[**ARC 7911B**, IAB 7/1/09, effective 7/1/09]

681—1.5(262) Registration and transcripts—general. A person may not be permitted to register for a course or courses at a state board of regents institution until any delinquent accounts owed by the person to an institution or any affiliated organization for which an institution acts as fiscal agent have been paid.

A state board of regents institution may withhold official transcripts of the academic record of a person until any delinquent accounts owed by the person to an institution or any affiliated organization for which an institution acts as fiscal agent have been paid.

This rule is intended to implement Iowa Code section 262.9.

681—1.6(262) College-bound program.

1.6(1) *Definitions.*

"Accredited private institution" means an institution of higher education as defined in Iowa Code section 261.9, subsection 5.

"Commission" means the college aid commission.

"Financial need" means the difference between the student's financial resources, including resources available from the student's parents and the student, as determined by a completed parents' financial statement and including any non-campus-administered federal or state grants and scholarships, and the student's estimated expenses while attending the institution. A student shall accept all available federal and state grants and scholarships before being considered eligible for grants under the Iowa minority academic grants for economic success program. Financial need shall be reconsidered on at least an annual basis.

"Full-time student" means an individual who is enrolled at an accredited private institution or board of regents university for at least 12 semester hours or the trimester or quarter equivalent.

"Minority person" means an individual who is black, Hispanic, Asian, or a Pacific Islander, American Indian, or an Alaskan Native American.

"Part-time student" means an individual who is enrolled at an accredited private institution or board of regents university in a course of study including at least three semester hours or the trimester or quarter equivalent of three semester hours.

"Program" means the Iowa minority academic grants for economic success program established in this division.

1.6(2) *Policy on college-bound program.*

a. The regent institutions will cooperate with other state and local agencies, including the department of education, the college aid commission, and educational institutions in implementing the college-bound program.

b. The universities will develop programs for elementary, middle and secondary school students and their families in the following areas:

(1) Encouragement to consider attending a postsecondary institution;

(2) Enrichment and academic preparation;

(3) Information about how to apply for admission.

c. College-bound program vouchers will be awarded to students on the basis of the participation of the student and the student's family in the college-bound program. One voucher will be awarded for participation in each college-bound program sponsored by a university.

(1) Each university will maintain records concerning those students who participate in the college-bound program, according to its established policies and procedures. The records will include information on those students who have received college-bound program vouchers which are described in Iowa Code section 262.92(2). The University of Iowa will maintain a central record on all students who have received college-bound program vouchers on behalf of all regent institutions and will make appropriate information available to the college aid commission.

(2) College-bound program vouchers may be used by students enrolled at a regent institution or at a private college or university in Iowa.

(3) A student holding vouchers and enrolling at a regent institution will receive priority in the award of funds under the Iowa minority academic grants for economic success (IMAGES) program. Awards under the IMAGES program are made on the basis of financial need. A student may be eligible for an additional award from the institution in which the student is enrolled.

(4) A student holding vouchers and enrolling at a private college or university in Iowa will receive priority in the award of funds under the Iowa minority academic grants for economic success program as provided by the rules of the college aid commission.

(5) The presidents, or their designees, will administer and coordinate the college-bound program at the universities. As part of the coordination, they will establish liaison with the appropriate state and local agencies, serve as the university contact and promote collaborative efforts among the regent universities and other appropriate agencies and institutions. Annual reports to the board of regents shall be prepared by each regent university. The reports shall contain relevant information as to the accomplishments of the program in the past year and a plan of action with goals and objectives for the forthcoming year. Reports shall be submitted to the board of regents on October 1 of each year.

This rule is intended to implement Iowa Code section 262.92.

681—1.7(262) Application fees. Application fees required for admission to the University of Iowa, Iowa State University and the University of Northern Iowa are as follows:

University of Iowa

Undergraduate domestic student	$40
Undergraduate international student	$85
Graduate/professional domestic student	$60
Graduate/professional international student	$100
PharmD student	$100
Re-entry fee	$20
Nondegree student	$40

Iowa State University

Undergraduate domestic student	$40
Undergraduate international student	$50
Graduate domestic student	$40
Graduate international student	$90
Veterinary Medicine	$75
Nondegree student	$40

University of Northern Iowa

Undergraduate domestic student	$40
Undergraduate international student	$50
Graduate domestic student	$50
Graduate international student	$70
Nondegree student	$40

This rule is intended to implement Iowa Code section 262.9(3).

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CHAPTER 9
POLICIES, PRACTICES AND PROCEDURES
[Prior to 4/20/88, Regents, Board of[720]]

681—9.1(262) Uniform rules of personal conduct.

9.1(1) *Definitions.* For purposes of these rules, the following words shall have the meaning set forth unless the context requires otherwise.

"Admission" means admission, readmission, reentry, registration, and reregistration as a student to any educational program of the university.

"Board" means the board of regents, state of Iowa.

"Campus" means all property owned or used by the university.

"Dismissal of a member of the faculty or staff" means termination of status as an employee without right of reemployment.

"Expulsion of a student" means termination of status as a student without right of readmission.

"Member of the faculty or staff" means all employees of the university.

"Person" means any student, member of the faculty or staff, or visitor.

"President" means the president (or acting president) of the university or any person or persons designated to act on the president's behalf for purposes of these rules.

"Student" means a person who is currently registered as a student at the university in an undergraduate, graduate or professional program on the campus, and includes students who have been suspended for a fixed period of time, during that fixed period; admitted students prior to enrollment; and persons continuing to work on a program of studies with the intent of returning to the university, even though not formally enrolled.

"Suspension of a member of the faculty or staff" means that during a specified period of time, the member of the faculty or staff is not eligible to continue as an employee of the university or to resume employment status or to be granted admission as a student. Subject to other rules and regulations of each institution concerning continued employment by the institution, a member of the faculty or staff who has been suspended for a specified period shall be reinstated by the university at the expiration of the suspension period provided that during the suspension period the member of the faculty or staff has not committed other acts of misconduct specified in 9.1(2) or in the policies of the university. A member of the faculty or staff under such suspension whose reemployment is denied on the basis of alleged acts of misconduct committed during a suspension period shall have a right to a hearing on that issue as provided in 9.1(3).

"Suspension of a student" means that during a specified period of time, the student shall be denied admission to the university. Subject to the rules and regulations of each institution concerning enrollment at the institution, a suspended student shall be reinstated to the university at the expiration of the suspension period provided that during the suspension period the student has not committed acts of misconduct specified in 9.1(2). A suspended student whose reinstatement is denied on the basis of alleged acts of misconduct committed during this suspension period shall have a right to a hearing on that issue, as provided in 9.1(3).

"University" means an institution of higher learning under the jurisdiction of the board. When used in the plural, the word means all institutions of higher learning under the jurisdiction of the board.

"Visitor" means any person on the campus who is not a student or a member of the faculty or staff.

9.1(2) *Rules of personal conduct.* The acts of misconduct defined in this subrule apply at the universities governed by the board. The universities are authorized to adopt other definitions of misconduct in addition to those in this rule. Any person, student, member of the faculty or staff, or visitor, who intentionally commits, attempts to commit, or incites or aids others in committing any of the following acts shall be subject to disciplinary action:

a. Obstruction or disruption of teaching, research, administration, disciplinary procedures, or other university or university-authorized function or event.

b. Unauthorized occupation or use of or unauthorized entry into any university facility. However, any entry into, use of, or occupation of any university facility by a student or member of the faculty or

staff, which does not violate any of the other rules of personal conduct set forth herein, shall be deemed unauthorized only if specifically prohibited, if that facility is closed at that time to general use or if the person fails to comply with proper notice to leave.

c. Physical abuse or the threat of physical abuse against any person on the campus or at or during any university-authorized function or event, or other conduct which threatens or endangers the health or safety of others.

d. Theft of or damage to property of the university or of a person on the campus or at or during any university-authorized function or event.

e. Interference with the right of access to university facilities or with any other lawful right of any person on the campus.

f. Setting a fire on the campus or at or during any university-authorized function or event without proper authority.

g. Use or possession on the campus or at or during any university-authorized function or event of firearms, ammunition, or other dangerous weapons, substances, or materials (except as expressly authorized by the university), or of bombs, explosives, or explosive or incendiary devices prohibited by law.

h. Participation in a riot or unlawful assembly, or failure to disperse, as defined by state law, whether such acts occur on or off the campus, if such act or failure to act occurs:

(1) In the contiguous metropolitan area in which any university governed by the board is located; or

(2) During a function or event authorized or sponsored by the university or an organization recognized by or affiliated with the university.

i. Conduct off campus which leads directly to a violation of any of paragraphs *"a"* to *"h"* of this subrule.

9.1(3) *Sanctions.*

a. Any student or member of the faculty or staff who is found after appropriate hearing to have violated any of the rules of personal conduct set forth in 9.1(2) may be sanctioned up to and including suspension, expulsion, or dismissal.

NOTE: "Appropriate hearing" as used throughout these rules means pursuant to existing hearing procedures in effect at the university for students and members of the faculty and staff.

A faculty or staff member who is suspended as a sanction under rule shall receive no salary during the period of suspension; provided, however, that payment shall be made for work done prior to the date of the suspension order.

b. A person who applies for reinstatement to or reemployment by the university after a term of suspension or dismissal may be denied such reinstatement or reemployment if it is found that such person has committed any acts of misconduct specified in 9.1(2) or in the policies of the university. A person denied reinstatement or reemployment under this subrule shall have a right to an appropriate hearing or to follow the grievance process of the university.

c. Any sanction imposed under 9.1(3)*"a"* and *"b"* shall have operative effect at all universities, and a person not eligible for admission to or employment by one university shall be barred similarly at the other universities.

9.1(4) *Emergency power.*

a. The president is authorized to declare a state of emergency to exist at the institution upon a determination that violent actions or disruptive activities at the university are of such a nature as:

(1) To present a clear and present danger to the orderly processes of the university or to persons or property on the campus, and

(2) To require extraordinary measures to:

1. Safeguard persons or property at such institution, or
2. Maintain educational or other legitimate institutional functions.

b. The state of emergency shall cease to exist automatically 48 hours after it is declared unless the president, after reviewing the situation, determines that it should be extended, such determination to be made under the standards established in 9.1(4)*"a"*(1) and 9.1(4)*"a"*(2). Each extension shall be for a

maximum period of 48 hours with a new determination being made for each extension. The president may declare the state of emergency to be over before the 48-hour period has run.

c. As soon as feasible after declaring a state of emergency, the president shall notify the board of actions taken.

d. Upon a finding by the president as set forth in 9.1(4)*"a,"* the president is authorized to take such action as may be necessary to eliminate or alleviate a clear and present danger to the orderly processes of the university and to safeguard persons or property at the university or to maintain educational or other legitimate university functions including barring a particular person or persons from the campus.

9.1(5) *Sanctions under emergency power.*

a. Any person who, after appropriate hearing, is found to have violated knowingly a presidential order issued as contemplated in 9.1(4) may be disciplined, up to and including expulsion or dismissal from the university.

b. Any person who, after appropriate hearing, is found to have violated during a state of emergency, knowing that a state of emergency has been declared, any of the regents' rules of personal conduct set forth in 9.1(2) of this policy may be disciplined, up to and including expulsion or dismissal from the university.

c. Any sanction imposed under this subrule shall have operative effect at all universities, and a person not eligible for admission to or employment by one university shall be barred similarly at the other universities.

9.1(6) *Constitutional rights.* The foregoing rules shall be construed so as not to abridge any person's constitutional right of free expression of thought or opinion, including the traditional American right to assemble peaceably and to petition authorities.

681—9.2(262) Transfers. All transfer applicants from any institution of higher learning to a university governed by the board of regents are asked about their eligibility to return to the institution from which the applicant is transferring. If the applicants are not eligible to return, the following rules apply:

9.2(1) *Transfers among regent institutions.* Transcripts at all regent universities now include an appropriate notation if a student is ineligible for readmission or reenrollment. Admission is denied if the applicant currently is under disciplinary suspension or has been dismissed from one of the other regent universities for violation of the regents' rules of personal conduct and is not eligible to reenter. Further, if such transfer applicant is currently on probation for having violated the regents' rules of personal conduct at one university, the applicant, if admitted to another regent university, is admitted on probation.

9.2(2) *Transfers from nonregent institutions.* If the application for admission or the transcript from another institution shows that the applicant is not eligible to reenroll there, further inquiry will be made to determine the reason. Such inquiry may lead to admission, conditional admission, or denial of admission. Appeals from the decision will be referred to appropriate university channels.

9.2(3) *Applications from "visitors."* "Visitors" to the campus who are believed to have violated the rules of personal conduct and who later apply for admission or employment may be denied admission or employment because of their prior conduct, subject to review if the denial is appealed by the applicant. An applicant who would be subject to such a denial and review at any university governed by the board of regents shall be subject to the same denial and review by the other two regent universities if application for admission or employment is made to them. The three universities shall cooperate in making known the identity of persons barred from admission or employment among all three institutions.

681—9.3(262) Alternate procedures when resources are not adequate. If, in the university president's judgment, the university's resources are not adequate to the task of providing hearings regarding violations of rules governing conduct at the institution on any particular occasion, the president may appoint one or more hearing examiners. Hearing examiners shall be licensed attorneys in the state of Iowa or shall have experience administering student judicial processes for a public institution.

681—9.4(23A) Policy on competition with private enterprise.

9.4(1) *Policy statement.* A primary responsibility of the board of regents is to oversee institutions whose missions include the creation and dissemination of knowledge. These missions encompass teaching, research, and services. To fulfill their missions effectively, institutions under the control of the state board of regents occasionally provide goods and services which enhance, promote, or support the instructional, research, public service, and other functions to meet the needs of students, faculty, staff, patients, visitors, and members of the public participating in institutional events.

It is the policy of the board of regents that the institutions shall not engage in competition with private enterprise unless the activity will assist in the education, research, extension or service mission of the institutions.

All activities involving the sale of goods, services, or facility usage shall be in accordance with an authorization and statement of purpose approved by the chief business officer at each institution. This approval will be given only after review which demonstrates that one or more of the following conditions are met:

a. The activity is deemed to be an integral part of the institution's educational, research, public service and campus support functions, and other educational and support activities.

b. The activity is needed to provide an integral good or service which is not reasonably available in the community; or the activity is needed to provide an integral good or service at time, price, location, or terms which are not reasonably available in the community.

c. The activity is carried out for the primary benefit of the campus community and is incidental to the education, research, service, or extension missions of the university.

d. The activity is carried out due to the importance of maintaining the quality of the institution.

9.4(2) *Definitions.*

"Institutions under the control of the state board of regents" means the State University of Iowa, the University of Northern Iowa, Iowa State University of science and technology, Iowa School for the Deaf, and Iowa Braille and Sight Saving School.

"Private enterprise" means an individual, firm, partnership, joint venture, corporation, association, or other legal entity engaging in the manufacturing, processing, sale, offering for sale, rental, leasing, delivery, dispensing, distributing, or advertising of goods or services for profit.

9.4(3) *Policy in writing.* Each institution under the control of the state board of regents shall have in writing:

a. A mechanism for reviewing proposed activities involving the sale of goods, provision of services, or usage of facilities to ensure that activities are consistent with board of regents policies; and

b. A procedure for receiving, reviewing, and responding to inquiries about activities carried out by the institution.

9.4(4) *Prohibition.* State board of regents institutions shall not engage in activities provided by private enterprise except as provided below.

9.4(5) *Exceptions provided by statute.* This prohibition does not apply to the on-campus activities of an institution under the control of the state board of regents as provided in Iowa Code section 23A.2(10)*"k"*(1) to (10).

9.4(6) *Exemptions.* The state board of regents exempts the following activities from the prohibition against competition with private enterprise.

a. Goods and services that are directly and reasonably related to the mission of the institution including (activities such as):

(1) Conferences, institutes, outreach programs, specialized centers and other efforts and programs which provide continuing education;

(2) Child day care services and health services provided to members of the university community;

(3) Educational media, publication, distribution, and audiovisual centers and services;

(4) Family and guest housing;

(5) Laundry, custodial, maintenance, and similar services.

b. Goods and services offered to only students, employees, or guests of the institution or school and which cannot be provided by private enterprise at the same or lower cost, including (activities such as):

(1) Gift shops which offer a limited and specialized array of goods;

(2) Specialized instruction in the visual or performing arts;

(3) Dormitory-based shops which serve students and offer a limited range of goods.

c. The acquisition, maintenance, and use of institutional aircraft and a vehicle fleet maintained for the purpose of transportation for educational and related purposes, including field trips.

d. Durable medical equipment or devices sold or leased for use off premises of an institution, school, or University of Iowa Hospitals and Clinics when:

(1) The equipment is needed to initiate or effectuate a treatment regimen (i.e., implants); or

(2) The equipment is essential to a rehabilitation program (i.e., crutches, prostheses); or

(3) The equipment is of a specialized nature and is not reasonably available elsewhere (i.e., customized or adaptive equipment for the handicapped); or

(4) A short-term supply of equipment is provided to avoid disruption in a treatment regimen when a patient is discharged.

e. Goods or services which are not otherwise available in the quantity or quality required by the institution, including (activities such as) specialized course materials, equipment, supplies, software, and publications.

f. Telecommunications systems utilized for communications within the institution's community of interest and broadcast and narrowcast communication systems, including microwave, fiber-optic and satellite communications.

g. Facilities, programs, and associated support services for fitness and recreation initiated and maintained primarily for the benefit of students, faculty, and staff.

h. Food services and sales located on campus and initiated and maintained primarily for the benefit of students, faculty, staff, and guests of the institution.

i. Sales of books, records, tapes, software, educational equipment and supplies offered primarily to students, faculty, and staff of the institution; sales of personal computers and associated hardware pursuant to institutional policy and limited to students, faculty, and staff.

9.4(7) *Provision for consultation with community and related business interests.* Each institution under the control of the state board of regents shall establish a mechanism for consultation with business interests in its community or area. This will involve the chief financial officer of the institution, and representatives of the institution, and will include the following:

a. Advising the institution on policies and procedures regarding the sale of goods or services which might compete with private enterprise.

b. Making recommendations, at the request of the institution, on particular activities.

c. Other duties as may be requested by the institution.

9.4(8) *Appeal process.* An appeal process is essential for resolving complaints involving competition with private enterprise.

a. A private enterprise which seeks to appeal an action or activity of an institution under the control of the state board of regents shall attempt to resolve the issue at the institutional level. The form of appeal to the institution shall be a letter to the chief business officer.

b. If the private enterprise is dissatisfied with the institution's response, the private enterprise may notify the executive director of the state board of regents and request assistance. This request shall be in writing and shall describe the action or activity which is being appealed.

c. The executive director may then take action to assist the private enterprise and the institution in resolving the issue.

d. If the issue remains unresolved, the executive director, at the request of the private enterprise, may docket the matter for review by the board of regents. If the matter is docketed, the executive director will prepare a recommendation for the board of regents to consider. A copy of the recommendation with notice of the time, date, and place of the meeting for which the matter has been docketed shall be transmitted to the private enterprise and the institutions prior to the meeting.

e. Board of regents action shall constitute a final agency action.

This rule is intended to implement Iowa Code chapter 23A.

681—9.5(262) Telecommunications policies and procedures.

9.5(1) *General or administrative.* The institutions governed by the regents view the statewide telecommunications network as one way to expand the ability of the universities to provide instruction and other information affecting professional and economic development throughout Iowa. The regents institutions utilize the Iowa communications network when appropriate for activities that include credit and noncredit courses, outreach programming, administrative meetings, professional development seminars and teleconferences.

9.5(2) *Designated coordinating agency.* As a means of facilitating efficient and effective utilization of the statewide telecommunications network by university faculty and staff, the universities have appointed Information Technology Services (ITS) as the principal agency on each campus responsible for arranging access to the system. ITS will assume an advisory role to interested users as well as represent a campus information source on statewide telecommunications issues. Additional responsibilities for ITS relating to the statewide telecommunications network include establishing a liaison with the network's management, coordinating campus financial transactions, and engaging campus entities to support the technical components required for collaborative efforts among the institutions governed by the board of regents.

9.5(3) *Credit, noncredit course offerings.* The regents institutions will facilitate use of the statewide telecommunications network wherever appropriate and cost-effective. The universities support a wide range of offerings, including credit and noncredit courses, professional development seminars, conferences and workshops. The originating college and department will retain exclusive jurisdiction over decisions pertaining to the instructional development process, including the choice of subject matter content, faculty, credit, student/participant requirements, and course or conference revision or withdrawal.

9.5(4) *Statewide coordination.* The regents institutions encourage collaborative efforts among the institutions governed by the board of regents involving the statewide telecommunications network.

[**ARC 0037C**, IAB 3/7/12, effective 4/11/12]

681—9.6(262) Notification to students on increases in tuition, fees, or charges.

9.6(1) Not less than 30 days prior to action by the board on any proposal to increase tuition, fees, or charges at one or more of the institutions of higher education under its control, the board of regents shall send written notification of the amount of the proposed increase and a copy of the memorandum relating to the proposed increase to the elected president of the government of the student body at each affected institution. The materials shall be sent to the person identified by each institution as the student government president and transmitted to the student government office listed in each university directory.

The final decision on the increase in tuition for a fiscal year shall be made at a regular meeting which is to be held in one of the three universities' cities but is not to be held during a university holiday or break.

9.6(2) If a proposal to increase tuition, fees, or charges at one of the universities is increased from the previous meeting's written proposal, or a new fee or charge is proposed, student leaders shall be sent copies of the agenda materials, and an additional 30 days' notice to students will be scheduled prior to board action on that portion of the proposal.

681—9.7(262) Distribution of docket information.

9.7(1) The statewide student organization representing the student government of each regent university shall be provided a copy of the docket of the board of regents on Friday preceding each meeting of the board of regents. Further, a copy of the docket shall be mailed on the Friday preceding the meeting to the elected president of the government of the student body at each university at the student government office listed in each university directory.

9.7(2) Legislators from the communities in which regent institutions are located, the majority and minority leadership in both houses, and legislators in the community where the board of regents meeting is to be held shall be provided a copy of the board's agenda five days in advance of the meeting.

These rules are intended to implement Iowa Code section 262.9(18) and chapters 262 and 23A.

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REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, Chapter 1245.

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VOLUNTARY DISCLOSURE PROGRAM

701—3.1(421,422,423) Voluntary disclosure program.

3.1(1) *Scope of the voluntary disclosure program.* Any person who is subject to Iowa tax or tax collection responsibilities may be eligible for the voluntary disclosure program. Being subject to Iowa tax may occur when a person has Iowa source income or has representatives or other presence in Iowa. Certain activities by such persons may create Iowa tax return filing requirements for Iowa source income, as defined in subrule 3.1(3), not previously reported. In addition, activities may also result in tax liabilities that are past due and owing.

3.1(2) *Purpose of the voluntary disclosure program.* The purpose of the voluntary disclosure program is to encourage unregistered business entities and persons to voluntarily contact the department regarding unreported Iowa source income. The person or the person's representative may initially contact the department on an anonymous basis. Anonymity of the taxpayer can be maintained until the voluntary disclosure agreement is executed by the taxpayer and the department. The voluntary disclosure program may be used by the department and the taxpayer to report previous periods of Iowa source income and to settle outstanding tax, penalty and interest liabilities, but it must also ensure future tax compliance by the taxpayer.

3.1(3) *Type of taxes eligible.* Only taxes, penalties and interest related to Iowa source income are eligible for settlement under the voluntary disclosure program. For purposes of this rule, "Iowa source income" means the tax base and the tax collection responsibility for the following enumerated taxes: corporate income tax, franchise tax, fiduciary income tax, withholding income tax, individual income tax, local option school district income surtax, state sales tax, state use tax, motor fuel taxes, cigarette and tobacco taxes, and local option taxes.

3.1(4) *Eligibility of the taxpayer.* The department has discretion to determine who is eligible for participation in the voluntary disclosure program. In making the determination, the department may consider the following factors:

a. The person must be subject to Iowa tax on Iowa source income or have Iowa tax collection responsibilities;

b. The person must not currently be under audit or examination by the department or under criminal investigation by the department;

c. The person must not have had any prior contact with the department or a representative of the department which could lead to audit or assessment associated with the tax types or tax periods sought to be addressed under the program;

d. The type and extent of activities resulting in Iowa source income;

e. Failure to report the Iowa source income or pay any liability was not due to fraud, intentional misrepresentation, an intent to evade tax, or willful disregard of Iowa tax laws; and

f. Any other factors which are relevant to the particular situation.

3.1(5) *Application to participate in the voluntary disclosure program.*

a. To apply for the voluntary disclosure program, the person or the person's representative must submit a written application to the Nonfiler Unit, Compliance Division, Iowa Department of Revenue, P.O. Box 10456, Des Moines, Iowa 50306-0456. To be valid, an application must include the following:

(1) The types of taxes involved;

(2) Separate statements evidencing compliance with each of the eligibility requirements set forth in subrule 3.1(4);

(3) A complete and accurate description of the person's activities resulting in Iowa source income, the source of the Iowa source income or Iowa tax collection responsibilities, the type and dates, if available, of the activities in Iowa, a description of the product or service sold in Iowa, and the number of activity occurrences in Iowa per year or whether the activities in Iowa per year were continuous;

(4) The reason for noncompliance with Iowa tax law;

(5) An estimation of the amount of unpaid Iowa tax by the tax type and applicable tax period(s); and

(6) Any other matters which are relevant to the particular situation.

b. The department reserves the right to request additional information that the department determines is necessary to determine or approximate the liability due, and to determine the applicant's eligibility, the accuracy of information presented and statements asserted by the applicant, and the terms of the voluntary disclosure agreement.

3.1(6) *Acceptance or rejection of an application for the voluntary disclosure program.* The department has the discretion to determine if an applicant meets all of the requirements for the voluntary disclosure program. The department will notify an applicant in writing regarding whether the applicant's application for participation in the program is accepted or rejected. Rejection of an application prior to the execution of an agreement may be based on the applicant's ineligibility; the applicant's noncompliance in submitting information, documents, evidence, or returns within the time period as requested by the department; misrepresentation of a material fact by the applicant or the applicant's representative; or the department's determination that the matter may be best handled by using other means of administration.

3.1(7) *Terms of the voluntary disclosure agreement.*

a. Discretion. The department has the discretion to settle all outstanding Iowa source income tax, penalty and interest liabilities of the eligible applicant. Settlement terms are on a case-by-case basis. The existence of the voluntary disclosure agreement and the terms of the agreement are to be held confidential by all parties to the agreement. Items considered by the department in determining the settlement terms include: the type of tax; the tax periods at issue; the reason for noncompliance; whether the tax is a trust fund tax; the types of activities resulting in the Iowa source income; the frequency of the activities that resulted in the Iowa source income; and any other matters which are relevant to the particular situation.

b. Maximum scope of audit. If a taxpayer initiates the contact with the department and is eligible for the voluntary disclosure program and complies with the agreement terms, the maximum prior years for which the department will generally audit and pursue settlement and collection will be five years, absent an intent to defraud, the making of material misrepresentations of fact, or an intent to evade tax.

c. Future filing requirements. All voluntary disclosure agreements must require that the applicant file future Iowa tax returns, unless the activity by the applicant resulting in the Iowa source income has changed or there has been a change in the law, rules, or court cases which dictate a different result.

d. Audit and assessment rights. The department reserves the right to audit all returns, spreadsheets or other documents submitted by the applicant or a third party to verify the facts and whether the terms of the voluntary disclosure agreement have been met. The department may audit information submitted by the applicant at any time within the allowed statutory limitation period. The department may also assess any tax, penalty, and interest found to be due in addition to the amount of original tax reported. The statute of limitations for assessment and statute of limitations for refunds begin to run as provided by law.

3.1(8) *Commencement of the voluntary disclosure agreement.* The voluntary agreement commences on the date of the execution of the voluntary disclosure agreement. Execution of the agreement is complete when the agreement is executed by the taxpayer and the department's authorized personnel. Prior to the execution of the voluntary disclosure agreement by the taxpayer and the department, the taxpayer is not protected from the department's regular audit process if the identity of the taxpayer, as an applicant, is unknown to the department. However, if the department has knowledge of the taxpayer's identity, as an applicant, the department will not take audit action against the taxpayer during the voluntary disclosure process. However, if a voluntary disclosure agreement is not reached, the department may assess tax, penalty and interest as provided by law at the time the identity of the applicant becomes known to the department.

3.1(9) *Voiding a voluntary disclosure agreement.*

a. Authority. The department also has the authority to declare a voluntary disclosure agreement null and void subsequent to the execution of the agreement. The department may void the contractual agreement if the department determines that a misrepresentation of a material fact was made by the person or a third party representing the person to the department. The department may also void a voluntary disclosure agreement if the department determines any of the following has occurred:

(1) The person does not submit information requested by the department within the time period specified by the department, including any extensions granted by the department;

(2) The person fails to file future Iowa returns as agreed to in the voluntary disclosure agreement;

(3) The person does not pay the agreed settlement liability within the time period designated by the department, including any extensions of time that may be granted by the department;

(4) The person does not remit all taxes imposed upon or collected by the person for all subsequent tax periods and all tax types that are subject to the voluntary disclosure agreement;

(5) The person fails to prospectively comply with Iowa tax law. Whether the person has failed to prospectively comply with Iowa tax law is determined by the department on a case-by-case basis;

(6) The person, based on a determination by the department, materially understates the person's tax liability; or

(7) The person has made a material breach of the terms of the voluntary disclosure agreement.

b. Audit rights. Voiding of the agreement results in nonenforceability of the agreement by the applicant and allows the department to proceed to assess tax, penalty and interest for that person's Iowa source income or tax collection responsibilities for all periods within the statute of limitations. The department reserves the right to audit all returns, spreadsheets or other documents submitted by the applicant or a third party and to make an assessment for all tax, penalty and interest owed, if the applicant is justifiably rejected for the voluntary disclosure program or the agreement between the person and the department is declared by the department to be null and void. If the voluntary disclosure agreement is voided or the application for the program is rejected and the department issues an assessment, the taxpayer may protest the assessment pursuant to 701—Chapter 7 and raise the issue of the propriety of voiding the voluntary disclosure agreement or rejecting the application. If the department does not issue an assessment, but does reject the application or voids the agreement, such action is not subject to appeal under 701—Chapter 7, but is considered to be "other agency action" as set forth in Iowa Code section 17A.19(3). See *Purethane Inc. v. Iowa State Board of Tax Review*, 498 N.W.2d 706 (Iowa 1993).

3.1(10) *Partnerships, partners, "S" corporations, shareholders in "S" corporations, trusts, and trust beneficiaries.* Once the department has initiated an audit or investigation of any type of partnership, partners of the partnership, "S" corporations, a shareholder in an "S" corporation, a trust, or trust beneficiaries, the department is deemed to have initiated an audit or investigation of the entity and of all those who receive Iowa source income from or have an interest in such an entity for purposes of eligibility under subrule 3.1(4) for participation in the voluntary disclosure program.

3.1(11) *Transfer or assignment.* The terms of the voluntary disclosure agreement are valid and enforceable by and against all parties, including their transferees and assignees.

3.1(12) *Confidentiality.* The terms of each voluntary disclosure contract are determined on a case-by-case basis. Except as may be specifically required by law or preexisting written agreement, the existence of a voluntary disclosure agreement and the terms of the voluntary disclosure agreement are to be held confidential by the parties to the voluntary disclosure agreement, their representatives, transferees, and assignees. Disclosure of the existence of a voluntary disclosure agreement or the terms of such an agreement in a manner contrary to this rule may result in the agreement being declared null and void at the discretion of the nondisclosing party.

This rule is intended to implement Iowa Code section 421.17.

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CHAPTER 164
TRAFFIC SAFETY IMPROVEMENT PROGRAM

761—164.1(312) Definitions.

"Jurisdiction" means the department, or the county or city having responsibility for and control over a road or street.

"Traffic safety fund" means the fund created for traffic safety improvement projects pursuant to Iowa Code section 312.2.

761—164.2(312) Information and forms. Information, instructions and application forms may be obtained from the Office of Traffic and Safety, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)239-1557.

761—164.3(312) Program administration.

164.3(1) *Purpose.* The traffic safety fund provides supplemental funding for traffic safety improvements or studies on public roads under county, city or state jurisdiction.

164.3(2) *Local participation.* The department shall administer the traffic safety fund as a statewide program and will encourage local participation in the review and evaluation of applications for funding.

164.3(3) *Funding.*

a. The commission shall review all applications and be responsible to program selected projects, subject to the availability of funds. The commission may fund all or part of a project and may make funding dependent upon adherence to a time schedule or fulfillment of specified conditions.

b. The commission need not commit all funds available during a fiscal year. Unexpended funds shall be retained for subsequent programming cycles.

c. The maximum traffic safety funding for a site-specific project shall generally not exceed $500,000. Total funding allotted for the traffic control device materials category shall not exceed $500,000 annually. Total funding allotted for all research, studies and public information initiatives shall not exceed $500,000 annually. All project costs exceeding the commitment of traffic safety funds shall be the responsibility of the applicant.

761—164.4(312) Applicant eligibility. The department, a county or an incorporated city in the state of Iowa is eligible to apply for traffic safety funds. Joint applications are encouraged when applicable, but the applicants shall designate one jurisdiction as the principal contact.

761—164.5(312) Project eligibility.

164.5(1) *Types of projects.* Eligible applications shall address needs in one of three categories: construction or improvement of traffic operations at a specific site; purchase of materials for initial installation or replacement of obsolete traffic control signs; or transportation safety research, studies or public safety information initiatives.

164.5(2) *Public roads.* Only applications involving a primary road, secondary road, or city street presently open to public use shall be considered. A project for a private purpose or road is not eligible.

761—164.6(312) Eligible project costs.

164.6(1) *Site-specific improvements.* The costs of construction or improvements eligible for traffic safety fund reimbursement include, but are not limited to, the following:

a. Road modernization, upgrading or reconstruction.

b. Bridge and culvert modernization, replacement or removal.

c. Road intersection and interchange improvement including channelization, traffic control devices or lighting.

d. Right-of-way required for a traffic safety project.

e. Drainage and erosion measures which are an integral part of the project.

f. Traffic control devices required by the project.

g. Guardrail.

h. Tree removal.

i. Other construction activities directly related to or required by the safety project.

164.6(2) *Traffic control devices.* The cost of materials purchased for initial installation of traffic control devices or replacement of obsolete traffic control devices to comply with the applicable warrants in the Manual on Uniform Traffic Control Devices (MUTCD) adopted in rule 761—130.1(321), Iowa Administrative Code, shall be eligible for funding.

164.6(3) *Research, studies and public information initiatives.* Funding shall be available for research, studies or public information initiatives related to traffic operations safety.

a. Research shall address statewide traffic safety concerns.

b. A study shall address remedies for traffic operations safety at a specific location. Study funds may be used to supplement federal Traffic Engineering Assistance Program (TEAP) funding.

c. A public information initiative shall emphasize traffic safety techniques or policies, and should be of statewide interest. An initiative of local scope may also be considered.

761—164.7(312) Ineligible project costs.

164.7(1) Any and all costs incurred prior to commission approval of funding for a project are ineligible.

164.7(2) Activities and costs not eligible for traffic safety funding as a portion of a site-specific improvement include, but are not limited to:

a. Routine maintenance of a road, street, bridge, culvert or traffic control device.

b. Safety-related activities associated with projects initiated for purposes other than traffic safety.

c. Contract administration costs.

d. Design and construction engineering and inspection.

e. Utility construction, reconstruction or adjustment, except as an integral part of a project.

f. Sidewalks, bicycle paths, or railroad-highway crossings, except as an integral part of a project.

g. Maintenance or energy costs for traffic control devices or lighting.

h. Expenditures for items not related to the roadway.

164.7(3) Activities and costs not eligible for traffic safety funding as a part of an application for traffic control device materials include, but may not be limited to:

a. Maintenance or energy costs for traffic control devices or lighting.

b. Installation costs.

761—164.8(312) Applications. Application procedures for each funding category will be distinct.

164.8(1) An application by a city or county for funding site-specific construction must be submitted on a departmental form specifically used for the traffic safety fund. Comparable information will be provided by the department for state-initiated projects. Required information shall include:

a. The applicant's name, mailing address, telephone number, and a designated contact person for the project.

b. A preliminary project concept statement, including a location map and a sketch plan. The concept must be reasonable from a traffic engineering standpoint and detailed enough to generate project cost estimates.

c. The justification for the proposed construction project. Justification may be based on a location's inclusion in the department's list of high accident locations, a TEAP-type study recommendation or a similar study generating a positive benefit/cost analysis for the proposed improvement.

d. Data showing the anticipated effect of the project on traffic safety. Data shall include accident history from the department's Accident Location Analysis System (ALAS) and the anticipated accident reduction, both in number and type, expected as a result of the project.

e. An itemized cost estimate for the project including a list of the sources and amounts of supplementary funds for the project.

f. A time schedule for the project.

g. The jurisdiction's official endorsement of the project and written assurance that the improved site will be adequately maintained.

164.8(2) An application for funding to pay the cost of materials for traffic control device installation shall be submitted in writing and shall include:

a. The applicant's name, mailing address, telephone number, and a designated contact person.

b. A list of the number and types of devices requested, and whether each is for initial placement or a replacement.

c. An inventory or similar documentation providing justification for the requested device.

d. A cost estimate and time schedule for installation after delivery.

e. The jurisdiction's official endorsement of the traffic control device project and written assurance that the traffic control device will be adequately maintained.

164.8(3) Research, a study or a public information initiative shall be proposed in writing and shall include:

a. The applicant's name, mailing address, telephone number and a designated contact person.

b. A description of the proposed subject matter and the goals or expected results of the effort.

c. A cost estimate.

761—164.9(312) Processing the application.

164.9(1) *Submission.*

a. The jurisdiction shall submit an original and three copies of the complete application to the office of traffic and safety. An application may be submitted at any time and shall be dated when received by the office of traffic and safety.

b. All complete applications received before August 15 of each year shall be evaluated for funding.

c. If an application is incomplete, the department shall return the application to the applicant to be resubmitted when complete. A resubmitted application shall be dated when received by the office of traffic and safety.

d. An unfunded application may be resubmitted for consideration during a subsequent funding period.

e. An application may be withdrawn at any time.

164.9(2) *Approval of projects.* Department staff shall prepare, with input from city and county officials, a proposed program of projects for each funding category and submit the programs to the commission for approval. The criterion for determining funding priorities in each category is the demonstrated relationship of the project to traffic safety.

[**ARC 7618B**, IAB 3/11/09, effective 4/15/09; **ARC 0033C**, IAB 3/7/12, effective 4/11/12]

761—164.10(312) Project agreement.

164.10(1) After the commission has approved funding for a county or city project, a project agreement shall be negotiated and executed between the department and the local jurisdiction. The agreement shall specify the conditions for project funding, which may include such items as the responsibility for planning, design, right-of-way, contracting, construction, materials inspection, documentation and the criteria for each. The agreement shall also specify the funding level for the eligible work items.

164.10(2) The department shall reimburse the county or city for actual eligible project costs not to exceed the amounts authorized by the project agreement.

164.10(3) Rescinded IAB 10/30/02, effective 12/4/02.

These rules are intended to implement Iowa Code section 312.2.

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CHAPTER 520
REGULATIONS APPLICABLE TO CARRIERS
[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 8]

761—520.1(321) Safety and hazardous materials regulations.

520.1(1) *Regulations.*

a. Motor carrier safety regulations. The Iowa department of transportation adopts the Federal Motor Carrier Safety Regulations, 49 CFR Parts 385 and 390-399 (October 1, 2011).

b. Hazardous materials regulations. The Iowa department of transportation adopts the Federal Hazardous Materials Regulations, 49 CFR Parts 107, 171-173, 177, 178, and 180 (October 1, 2011).

c. Copies of regulations. Copies of the federal regulations may be reviewed at the state law library or through the Internet at http://www.fmcsa.dot.gov.

520.1(2) *Carriers subject to regulations.*

a. Operators of commercial vehicles, as defined in Iowa Code section 321.1, are subject to the Federal Motor Carrier Safety Regulations adopted in this rule unless exempted under Iowa Code section 321.449.

b. Operators of vehicles transporting hazardous materials in commerce are subject to the Federal Hazardous Materials Regulations adopted in this rule unless exempted under Iowa Code section 321.450.

c. Operators of vehicles for hire, designed to transport 7 or more persons, but fewer than 16, including the driver, must comply with 49 CFR Part 395 of the Federal Motor Carrier Safety Regulations. In addition, operators of vehicles for hire designed to transport 7 or more persons, but fewer than 16, including the driver, are not exempt from logbook requirements afforded the 100-air-mile radius driver under 49 CFR 395.1(e). However, the provisions of 49 CFR Part 395 shall not apply to vehicles offered to the public for hire that are used principally in intracity operation and are regulated by local authorities.

520.1(3) *Declaration of knowledge of regulations.* Operators of commercial vehicles who are subject to the regulations adopted in this rule shall at the time of application for authority to operate in Iowa or upon receipt of their Iowa registration declare knowledge of the Federal Motor Carrier Safety Regulations and Federal Hazardous Materials Regulations adopted in this rule.

This rule is intended to implement Iowa Code sections 321.1, 321.449 and 321.450.

[**ARC 7750B**, IAB 5/6/09, effective 6/10/09; **ARC 8720B**, IAB 5/5/10, effective 6/9/10; **ARC 9493B**, IAB 5/4/11, effective 6/8/11; **ARC 0034C**, IAB 3/7/12, effective 4/11/12]

761—520.2(321) Definitions. The following definitions apply to the regulations adopted in rule 761—520.1(321):

"Any requirements which impose any restrictions upon a person" as used in Iowa Code section 321.449(6) means the requirements in 49 CFR Parts 391 and 395.

"Driver age qualifications" as used in Iowa Code section 321.449(3) means the age qualifications in 49 CFR 391.11(b)(1).

"Driver qualifications" as used in Iowa Code section 321.449(2) means the driver qualifications in 49 CFR Part 391.

"Farm customer" as used in Iowa Code section 321.450, unnumbered paragraph 3, means a retail consumer residing on a farm or in a rural area or city with a population of 3000 or less.

"Gasoline" as used in Iowa Code section 321.450, first unnumbered paragraph, means leaded gasolines, no-lead gasolines, ethanol and ethanol-blended gasolines, aviation gasolines, number 1 and number 2 fuel oils, diesel fuels, aviation jet fuels and kerosene.

"Hours of service" as used in Iowa Code section 321.449(2) means the hours of service requirements in 49 CFR Part 395.

"Record-keeping requirements" as used in Iowa Code section 321.449(2) means the record-keeping requirements in 49 CFR Part 395.

"Rules adopted under this section concerning physical and medical qualifications" as used in Iowa Code section 321.449(5) and Iowa Code section 321.450, unnumbered paragraph 2, means the regulations in 49 CFR 391.11(b)(4) and 49 CFR Part 391, Subpart E.

"Rules adopted under this section for a driver of a commercial vehicle" as used in Iowa Code section 321.449(4) means the regulations in 49 CFR Parts 391 and 395.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.3(321) Motor carrier safety regulations exemptions.

520.3(1) The following intrastate vehicle operations are exempt from the motor carrier safety regulations concerning inspection in 49 CFR Part 396.17 as adopted in rule 761—520.1(321):

a. Implements of husbandry including nurse tanks as defined in Iowa Code section 321.1.

b. Special mobile equipment (SME) as defined in Iowa Code section 321.1.

c. Unregistered farm trailers as defined in 761—subrule 400.1(3), pursuant to Iowa Code section 321.123.

d. Motor vehicles registered for a gross weight of five tons or less when used by retail dealers or their employees to deliver hazardous materials, fertilizers, petroleum products and pesticides to farm customers.

520.3(2) Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.123, 321.449 and 321.450.

761—520.4(321) Hazardous materials exemptions. These exemptions apply to the regulations adopted in rule 761—520.1(321):

520.4(1) Pursuant to Iowa Code section 321.450, unnumbered paragraph 3, "retail dealers of fertilizers, petroleum products, and pesticides and their employees while delivering fertilizers, petroleum products and pesticides to farm customers within a 100-air-mile radius of their retail place of business" are exempt from 49 CFR 177.804; and, pursuant to Iowa Code section 321.449(4), they are exempt from 49 CFR Parts 391 and 395. However, pursuant to Iowa Code section 321.449, the retail dealers and their employees under the specified conditions are subject to the regulations in 49 CFR Parts 390, 392, 393, 396 and 397.

520.4(2) Rescinded IAB 3/10/99, effective 4/14/99.

This rule is intended to implement Iowa Code section 321.450.

761—520.5(321) Safety fitness.

520.5(1) *New motor carrier safety audits.* Peace officers in the office of motor vehicle enforcement of the Iowa department of transportation shall perform safety audits of new motor carriers and shall have the authority to enter a motor carrier's place of business for the purpose of performing these audits. These audits shall be performed in compliance with 49 CFR Part 385 and shall be completed within 18 months from the day the motor carrier commences business.

520.5(2) *Motor carrier compliance reviews.* Peace officers in the office of motor vehicle enforcement of the Iowa department of transportation shall perform compliance reviews of motor carriers and shall have the authority to enter a motor carrier's place of business for the purpose of performing these compliance reviews. These compliance reviews shall be performed in compliance with 49 CFR Part 385.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.6(321) Out-of-service order. A person shall not operate a commercial vehicle or transport hazardous material in violation of an out-of-service order issued by an Iowa peace officer. An out-of-service order for noncompliance shall be issued when either the vehicle operator is not qualified to operate the vehicle or the vehicle is unsafe to be operated until required repairs are made. The out-of-service order shall be consistent with the North American Uniform Out-of-Service Criteria.

This rule is intended to implement Iowa Code sections 321.3, 321.208A, 321.449, and 321.450.

761—520.7(321) Driver's statement. A "driver" as used in Iowa Code section 321.449(5) and Iowa Code section 321.450, unnumbered paragraph 2, shall carry at all times a notarized statement of employment. The statement shall include the following:

1. The driver's name, address and social security number;

2. The name, address and telephone number of the driver's pre-July 29, 1996, employer;

3. A statement, signed by the pre-July 29, 1996, employer or the employer's authorized representative, that the driver was employed to operate a commercial vehicle only in Iowa; and

4. A statement showing the driver's physical or medical condition existed prior to July 29, 1996.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.8(321) Agricultural operations. The provisions of 49 CFR Part 395.3 shall not apply to drivers transporting agricultural commodities or farm supplies for agricultural purposes in Iowa if such transportation:

1. Is limited to an area within a 100-air-mile radius from the source of the commodities or the distribution point from the farm supplies, and

2. Is conducted only during the time frames of March 15 through June 30 and October 4 through December 14.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

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[1] Effective date of 520.1(1)*"a"* and *"b";* rescission of 520.1(2)*"b";* and 520.3 delayed until adjournment of the 1993 Regular Session of the General Assembly by the Administrative Rules Review Committee at its meeting held October 14, 1992; delay lifted by the Committee November 10, 1992.

CHAPTER 607
COMMERCIAL DRIVER LICENSING

761—607.1(321) Scope. This chapter applies to licensing persons for the operation of commercial motor vehicles. Unless otherwise stated, the provisions of this chapter are in addition to other motor vehicle licensing rules.

This rule is intended to implement Iowa Code chapter 321.

761—607.2(17A) Information.

607.2(1) *Information and location.* Applications, forms and information about the commercial driver's license (CDL) are available at any driver's license examination station. Assistance is also available by mail from the Office of Driver Services, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (800)532-1121 or (515)244-8725; or by facsimile at (515)237-3071.

607.2(2) *Manual.* A copy of a study manual for the commercial driver's license tests is available upon request at any driver's license examination station.

This rule is intended to implement Iowa Code section 17A.3.

761—607.3(321) Definitions. The definitions in Iowa Code section 321.1 apply to this chapter of rules. In addition, the following definitions are adopted:

"Air brake system" means a system that uses air as a medium for transmitting pressure or force from the driver's control to the service brake. "Air brake system" shall include any braking system operating fully or partially on the air brake principle.

"Commercial driver's license" or *"CDL"* means a license issued to an individual by a state or other jurisdiction of domicile, in accordance with the standards contained in 49 CFR Part 383, which authorizes the individual to operate a class of a commercial motor vehicle.

"Commercial driver's license downgrade" or *"CDL downgrade"* means either:

1. The driver changes the driver's self-certification of type of driving from non-excepted interstate to excepted interstate, non-excepted intrastate, or excepted intrastate driving, or
2. The department removed the CDL privilege from the driver's license.

"Commercial driver's license information system driver's record" or *"CDLIS driver's record"* means the electronic record of the individual's CDL driver's status and history stored by the state-of-record as part of the commercial driver's license information system established under 49 U.S.C. Section 31309.

"Commercial motor vehicle" as defined in Iowa Code section 321.1 does not include a motor vehicle designed as off-road equipment rather than as a motor truck, such as a forklift, motor grader, scraper, tractor, trencher or similar industrial-type equipment. "Commercial motor vehicle" also does not include self-propelled implements of husbandry described in Iowa Code subsection 321.1(32).

"Controlled substance" as used in Iowa Code section 321.208 means a substance defined in Iowa Code section 124.101.

"Medical examiner" means a person who is licensed, certified or registered, in accordance with applicable state laws and regulations, to perform physical examinations. The term includes but is not limited to doctors of medicine, doctors of osteopathy, physician assistants, advanced registered nurse practitioners, and doctors of chiropractic.

"Medical examiner's certificate" means a certificate completed and signed by a medical examiner under the provisions of 49 CFR Section 391.43.

"Medical variance" means a driver has received one of the following from the Federal Motor Carrier Safety Administration that allows the driver to be issued a medical certificate:

1. An exemption letter permitting operation of a commercial motor vehicle pursuant to 49 CFR Part 381, Subpart C, or 49 CFR Section 391.62, or 49 CFR Section 391.64.
2. A skill performance evaluation certificate permitting operation of a commercial motor vehicle pursuant to 49 CFR Section 391.49.

"Passenger vehicle" means either of the following:

1. A motor vehicle designed to transport 16 or more persons including the operator.

2. A motor vehicle of a size and design to transport 16 or more persons including the operator which is redesigned or modified to transport fewer than 16 persons with disabilities. The size of a redesigned or modified vehicle shall be any such vehicle with a gross vehicle weight rating of 10,001 or more pounds.

"School bus" means a commercial motor vehicle used to transport pre-primary, primary, or secondary school students from home to school, from school to home, or to and from school-sponsored events. "School bus" does not include a bus used as a common carrier.

"Self-certification" means a written certification of which category of type of driving an applicant for a commercial driver's license engages in or intends to engage in, from the following categories:

1. Non-excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, is both subject to and meets the qualification requirements under 49 CFR Part 391, and is required to obtain a medical examiner's certificate by 49 CFR Section 391.45.

2. Excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, but engages exclusively in transportation or operations excepted under 49 CFR Section 390.3(f), 391.2, 391.68 or 398.3 from all or parts of the qualification requirements of 49 CFR Part 391, and is therefore not required to obtain a medical examiner's certificate by 49 CFR Section 391.45.

3. Non-excepted intrastate. The person certifies that the person operates only in intrastate commerce and is subject to state driver qualification requirements.

4. Excepted intrastate. The person certifies that the person operates only in intrastate commerce, but engages exclusively in transportation or operations excepted from all or parts of the state driver qualification requirements as set forth in Iowa Code section 321.449.

"State," as used in "another state" in Iowa Code subsection 321.174(2), "Former state of residence" in Iowa Code subsection 321.188(5), or "any state" in Iowa Code subsection 321.208(1), means one of the United States, the District of Columbia, a Canadian province or a Mexican state unless the context means the state of Iowa.

This rule is intended to implement Iowa Code sections 321.1, 321.174, 321.191, 321.193 and 321.208 and 2011 Iowa Code Supplement sections 321.188 and 321.207.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09; **ARC 9954B**, IAB 1/11/12, effective 1/30/12; **ARC 0031C**, IAB 3/7/12, effective 4/11/12]

761—607.4 and **607.5** Reserved.

761—607.6(321) Exemptions.

607.6(1) *Persons exempt.* A person listed in Iowa Code section 321.176A is exempt from commercial driver licensing requirements.

607.6(2) *Exempt until April 1, 1992.* Rescinded IAB 6/23/93, effective 7/28/93.

This rule is intended to implement Iowa Code sections 321.1 and 321.176A.

761—607.7(321) Records. The operating record of a person who has been issued a commercial driver's license or a person who has been disqualified from operating a commercial motor vehicle shall be maintained as provided in the department's "Record Management Manual" adopted in 761—Chapter 4.

This rule is intended to implement Iowa Code sections 22.11, 321.12 and 321.199.

761—607.8 and **607.9** Reserved.

761—607.10(321) Adoption of federal regulations.

607.10(1) *Code of Federal Regulations.* The department adopts the following portions of the Code of Federal Regulations which are referenced throughout this chapter of rules:

a. 49 CFR Section 391.11 as adopted in 761—Chapter 520.

b. 49 CFR Section 392.5 as adopted in 761—Chapter 520.

c. The following portions of 49 CFR Part 383 (October 1, 2011):

(1) Section 383.51(b), Disqualification for major offenses, and Section 383.51(a)(5), Reinstatement after lifetime disqualification.

(2) Subpart E—Testing and Licensing Procedures, which contains Sections 383.71-383.77.

(3) Subpart G—Required Knowledge and Skills, which contains Sections 383.110-383.123.

(4) Subpart H—Tests, which contains Sections 383.131-383.135.

607.10(2) *Copies of regulations.* Copies of the federal regulations may be reviewed at the state law library or through the Internet at http://www.fmcsa.dot.gov.

This rule is intended to implement Iowa Code sections 321.187, 321.188, 321.208 and 321.208A and 2011 Iowa Code Supplement section 321.207.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09; **ARC 9954B**, IAB 1/11/12, effective 1/30/12; **ARC 0031C**, IAB 3/7/12, effective 4/11/12]

761—607.11 to **607.14** Reserved.

761—607.15(321) Application. An applicant for a commercial driver's license shall comply with the requirements of Iowa Code sections 321.182 and 321.188 and 761—Chapter 601.

This rule is intended to implement Iowa Code sections 321.182 and 321.188.

761—607.16(321) Commercial driver's license (CDL).

607.16(1) *Classes.* The department may issue a commercial driver's license only as a Class A, B or C driver's license. The license class identifies the types of vehicles that may be operated. A commercial driver's license may have endorsements which authorize additional vehicle operations or restrictions which limit vehicle operations.

607.16(2) *Validity.*

a. A Class A commercial driver's license allows a person to operate a combination of commercial motor vehicles as specified in Iowa Code paragraph 321.189(1)*"a."* With the required endorsements and subject to the applicable restrictions, a Class A commercial driver's license is valid to operate any vehicle.

b. A Class B commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)*"b."* With the required endorsements and subject to the applicable restrictions, a Class B commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A commercial driver's license.

c. A Class C commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)*"c."* With the required endorsements and subject to the applicable restrictions, a Class C commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A or Class B commercial driver's license.

d. A commercial driver's license is valid for operating a motorcycle as a commercial motor vehicle only if the license has a motorcycle endorsement and a hazardous material endorsement. A commercial driver's license is valid for operating a motorcycle as a noncommercial motor vehicle only if the license has a motorcycle endorsement.

e. A commercial driver's license valid for five years shall be issued to a qualified applicant who is at least 18 years of age but not yet 70 years of age.

f. A commercial driver's license valid for two years shall be issued to a qualified applicant 70 years of age or older. A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

g. A commercial driver's license is valid for 60 days after the expiration date.

h. A person with a commercial driver's license valid for the vehicle operated is not required to obtain a Class D driver's license to operate the vehicle as a chauffeur.

607.16(3) *Requirements.*

a. The minimum age to obtain a commercial driver's license is 18 years.

b. The applicant shall meet the requirements of Iowa Code sections 321.182 and 321.188.

This rule is intended to implement Iowa Code sections 321.177, 321.182, 321.188, 321.189, and 321.196.

761—607.17(321) Endorsements. All endorsements except the hazardous material endorsement continue to be valid without retesting or additional fees when renewing or upgrading a license. The endorsements that authorize additional commercial motor vehicle operations with a commercial driver's license are:

607.17(1) *Hazardous material.* A hazardous material endorsement (Hazmat) is required to transport hazardous material of a type or quantity requiring placarding. Upon license renewal, retesting and fee payment are required. Retesting and fee payment are also required when an applicant upgrades an Iowa license or transfers a commercial driver's license from another state unless the applicant provides evidence of passing the endorsement test within the preceding 24 months. A farmer or a person working for a farmer is not subject to the hazardous material endorsement while operating either a pickup or a special truck within 150 air miles of the farmer's farm to transport supplies to or from the farm.

607.17(2) *Passenger vehicle.* A passenger vehicle endorsement (Pass) is required to operate a passenger vehicle as defined in rule 761—607.3(321).

607.17(3) *Tank vehicle.* A tank vehicle endorsement (Tank) is required to operate a tank vehicle as defined in Iowa Code section 321.1. A commercial motor vehicle upon which is transported an empty storage tank as the vehicle cargo is not a tank vehicle. A vehicle transporting a tank, regardless of the tank's capacity, which does not otherwise meet the definition of a commercial motor vehicle in Iowa Code section 321.1 is not a tank vehicle.

607.17(4) *Double/triple trailer.* A double/triple trailer endorsement (Dbl/Trpl Trlr) is required to operate a commercial motor vehicle with two or more towed trailers when the combination of vehicles meets the criteria for a Class A commercial motor vehicle. Operation of a triple trailer combination vehicle is not permitted in Iowa.

607.17(5) *Hazardous material and tank.* A combined endorsement (Hazmat & Tank) authorizes both hazardous material and tank vehicle operations.

607.17(6) *School bus.* After September 30, 2005, a school bus endorsement is required to operate a school bus as defined in rule 761—607.3(321). An applicant for a school bus endorsement must also qualify for a passenger vehicle endorsement.

607.17(7) *Exceptions for towing operations.*

a. A driver who tows a vehicle in an emergency "first move" from the site of a vehicle malfunction or accident on a highway to the nearest appropriate repair facility is not required to have the endorsement(s) applicable to the towed vehicle. In any subsequent move, a driver who tows a vehicle from one repair or disposal facility to another is required to have the endorsement(s) applicable to the towed vehicle with one exception: A tow truck driver is not required to have a passenger endorsement to tow a passenger vehicle.

b. The double/triple trailer endorsement is not required to operate a commercial motor vehicle with two or more towed vehicles that are not trailers.

This rule is intended to implement Iowa Code sections 321.1, 321.176A, and 321.189.

761—607.18(321) Restrictions. The restrictions that may limit commercial motor vehicle operation with a commercial driver's license are listed in 761—subrule 605.5(3) and are explained below:

607.18(1) *Air brake.* The air brake restriction (Vehicle without air brakes) prohibits the operation of a commercial motor vehicle equipped with an air brake system, as defined in rule 761—607.3(321), until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when renewing the license.

607.18(2) *Class B vehicle.* The Class B vehicle restriction (except tractor-trailer) prohibits operation of a motor vehicle that meets the criteria for a Class A commercial motor vehicle.

607.18(3) *Class B passenger vehicle.* The Class B passenger vehicle restriction (except Class A bus) prohibits operation of a passenger vehicle that meets the criteria for a Class A commercial motor vehicle.

607.18(4) *Class C passenger vehicle.* The Class C passenger vehicle restriction (except Class A and Class B bus) prohibits operation of a passenger vehicle that meets the criteria for a Class A or Class B commercial motor vehicle.

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

761—607.19 Reserved.

761—607.20(321) Commercial driver's instruction permit.

607.20(1) *Validity.*

a. A commercial driver's instruction permit allows the permit holder to operate a commercial motor vehicle when accompanied by a person licensed for the vehicle being operated. Examples of permissible vehicle operation include but are not limited to:

(1) Operation of a vehicle requiring a higher class license than the license to which the permit is added.

(2) Operation of a vehicle requiring an endorsement other than a hazardous material endorsement.

(3) Operation of a vehicle equipped with air brakes.

b. A commercial driver's instruction permit is valid for six months and may be renewed once within two years from the date of issuance of the first permit.

c. A commercial driver's instruction permit is invalid after the expiration date of the license to which the permit is added or the expiration date of the permit whichever occurs first.

607.20(2) *Requirements.*

a. An applicant for a commercial driver's instruction permit must be at least 18 years of age and eligible for a commercial driver's license.

b. The applicant must have a valid Class A, B, C, or D license other than an instruction permit, a special instruction permit, a motorized bicycle license or a temporary restricted license.

c. The applicant must successfully pass the general knowledge test for a commercial driver's license.

This rule is intended to implement Iowa Code sections 321.180, 321.186 and 321.188.

761—607.21 to **607.24** Reserved.

761—607.25(321) Examination for a commercial driver's license. In addition to the requirements of 761—Chapter 604, an applicant for a commercial driver's license shall pass the knowledge and skills tests as required in 49 CFR Part 383, Subparts G and H.

This rule is intended to implement Iowa Code section 321.186.

761—607.26(321) Vision screening. An applicant for a commercial driver's license must pass a vision screening test administered by the department. The vision standards are given in 761—604.11(321).

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

761—607.27(321) Knowledge tests.

607.27(1) *General knowledge test.* The general knowledge test for a commercial driver's license is a written test of topics such as vehicle inspection, operation, safety and control in accordance with 49 CFR Section 383.111.

607.27(2) *Additional tests.* In addition to the general knowledge test for a commercial driver's license, an additional knowledge test is required for each of the following:

a. Class A license for combination vehicle operation as required in 49 CFR Section 383.111.

b. Hazardous material endorsement as required in 49 CFR Section 383.121. The knowledge test for a hazardous material endorsement shall not be administered orally or in a language other than English.

c. Passenger vehicle endorsement as required in 49 CFR Section 383.117.

d. Tank vehicle endorsement as required in 49 CFR Section 383.119.

e. Double/triple trailer endorsement as required in 49 CFR Section 383.115.

f. School bus endorsement as required in 49 CFR Section 383.123. The applicant must also qualify for a passenger vehicle endorsement.

g. Removal of the air brake restriction as required in 49 CFR Section 383.111.

607.27(3) *Oral test.* An oral test shall be offered only at specified locations. Information about the locations is available at any driver's license examination station.

607.27(4) *Waiver.* A waiver of any knowledge test is permitted only as provided in Iowa Code subsection 321.188(5). The burden of proof of having passed the hazardous material endorsement test within the preceding 24 months rests with the applicant.

607.27(5) *Requirement.* An applicant must pass the applicable knowledge test(s) before taking the skills test.

This rule is intended to implement Iowa Code sections 321.186 and 321.188.

761—607.28(321) Skills test.

607.28(1) *Content and order.* The skills test for a commercial driver's license is a three-part test as required in 49 CFR Part 383, Subparts E, G and H. The three parts must be taken in the following order: the pretrip inspection, the basic vehicle control skills, and an on-the-road driving demonstration. Those elements of the skills test that are not applicable to the vehicle being used in the skills test may be waived by the department. The basic vehicle control skills may be accomplished as part of the on-the-road driving demonstration. The department shall terminate the skills test when it is determined that the applicant has failed the test.

607.28(2) *Vehicle.* The applicant shall provide a representative vehicle for the skills test. "Representative vehicle" means a commercial motor vehicle that meets the statutory description for the class of license applied for.

a. To obtain a passenger vehicle endorsement applicable to a specific vehicle class, the applicant must take the skills test in a passenger vehicle, as defined in rule 761—607.3(321), satisfying the requirements of that class, as required in 49 CFR Section 383.117.

b. To obtain a school bus endorsement, the applicant must qualify for a passenger vehicle endorsement and take the skills test in a school bus, as defined in rule 761—607.3(321), in the same vehicle class as the applicant will drive, as required in 49 CFR Section 383.123. Up to and including September 30, 2005, the skills test for a school bus endorsement is waived for an applicant meeting the requirements of 49 CFR Section 383.123(b).

c. To remove an air brake restriction, the applicant must take the skills test in a vehicle equipped with an air brake system, as defined in rule 761—607.3(321) and as required in 49 CFR Section 383.113.

607.28(3) *Locations.* The skills test for a commercial driver's license shall be given only at specified locations where adequate testing facilities are available. An applicant may contact any driver's license examination station for the location of the nearest skills testing station. A skills test by appointment shall be offered only at specified regional test sites.

This rule is intended to implement Iowa Code sections 321.186 and 321.188.

761—607.29(321) Waiver of skills test. Rescinded IAB 6/23/93, effective 7/28/93.

761—607.30 Reserved.

761—607.31(321) Test results.

607.31(1) *Proof of passing score.* When necessary, the department shall issue a form valid for 90 days showing the knowledge test(s) or part(s) of the skills test that the applicant passed. The applicant shall retain the form(s) until all tests are passed and present the form(s) to the department to obtain the license.

607.31(2) *Retesting.* An applicant shall be required to repeat only the knowledge test(s) or part(s) of the skills test that the applicant failed. An applicant who fails a test shall not be permitted to repeat that test the same day.

This rule is intended to implement Iowa Code section 321.186.

761—607.32 to **607.34** Reserved.

761—607.35(321) Issuance of commercial driver's license. A commercial driver's license issued by the department shall be identified by "commercial driver's license" or "CDL" on the face of the license.

This rule is intended to implement Iowa Code section 321.189.

761—607.36(321) Conversion to commercial driver's license. Rescinded IAB 6/23/93, effective 7/28/93.

761—607.37(321) Commercial driver's license renewal.

607.37(1) To renew a commercial driver's license, the licensee shall apply at a driver's license examination station, certify eligibility and, if required, pass the appropriate test(s).

607.37(2) A valid commercial driver's license may be renewed 30 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier, not to exceed one year prior to the expiration date. The department may allow renewal earlier than one year prior to the expiration date for active military personnel being deployed due to actual or potential military conflict.

607.37(3) A valid commercial driver's license may be renewed within 60 days after the expiration date, unless otherwise specified.

This rule is intended to implement Iowa Code sections 321.186 and 321.196.

761—607.38(321) Transfers from another state. Upon initial application for an Iowa license, an Iowa resident who has a valid commercial driver's license from a former state of residence is not required to retest except as specified in Iowa Code subsection 321.188(5) but is required to pay the applicable endorsement and restriction removal fees.

This rule is intended to implement Iowa Code sections 321.188 and 321.191.

761—607.39(321) Disqualification.

607.39(1) *Date.* A disqualifying act, action or offense under Iowa Code section 321.208, that occurred before July 1, 1990, shall not be grounds for disqualification from operating a commercial motor vehicle.

607.39(2) *Notice.* A 30-day advance notice of disqualification shall be served by the department in accordance with rule 761—615.37(321). Pursuant to Iowa Code subsection 321.208(9), a peace officer on behalf of the department may serve the notice of disqualification immediately.

607.39(3) *Hearing and appeal process.* A person who has received a notice of disqualification may contest the disqualification in accordance with 761—615.38(17A,321).

607.39(4) *Reduction of lifetime disqualification.* Reserved.

This rule is intended to implement Iowa Code chapter 17A and section 321.208.

761—607.40(321) Sanctions. When a person's motor vehicle license is denied, canceled, suspended, revoked or barred, the person is also disqualified from operating a commercial motor vehicle.

This rule is intended to implement Iowa Code section 321.208.

761—607.41 to **607.44** Reserved.

761—607.45(321) Reinstatement. To reinstate a commercial driver's license after completion of a period of disqualification, a person shall appear at a driver's license examination station. The person must also meet the vision standards for licensing, pass the applicable knowledge test(s) and the skills test, and pay the required reinstatement fee and the fees for a new license.

This rule is intended to implement Iowa Code sections 321.191 and 321.208.

761—607.46 to **607.48** Reserved.

761—607.49(321) Restricted commercial driver's license.

607.49(1) *Scope.* This rule pertains to the issuance of restricted commercial driver's licenses to suppliers or employees of suppliers of agricultural inputs. Issuance is permitted by 49 CFR 383.3(f). A restricted commercial driver's license shall meet all requirements of a regular commercial driver's license, as set out in Iowa Code chapter 321 and this chapter of rules, except as specified in this rule.

607.49(2) *Agricultural inputs.* The term "agricultural inputs" means suppliers or applicators of agricultural chemicals, fertilizer, seed or animal feeds.

607.49(3) *Validity.*

a. A restricted commercial driver's license allows the licensee to drive a commercial motor vehicle for agricultural input purposes. The license is valid to:

(1) Operate Group B and Group C commercial motor vehicles including tank vehicles and vehicles equipped with air brakes, except passenger vehicles.

(2) Transport the hazardous materials listed in paragraph 607.49(3)*"b."*

(3) Operate only during the current, validated seasonal period.

(4) Operate between the employer's place of business and the farm currently being served, not to exceed 150 miles.

b. A restricted commercial driver's license is not valid for transporting hazardous materials requiring placarding, except as follows:

(1) Liquid fertilizers such as anhydrous ammonia may be transported in vehicles or implements of husbandry with total capacities of 3,000 gallons or less.

(2) Solid fertilizers such as ammonium nitrate may be transported provided they are not mixed with any organic substance.

(3) A hazardous material endorsement is not needed to transport the products listed in the preceding subparagraphs.

c. When not driving for agricultural input purposes, the license is valid for operating a noncommercial motor vehicle that may be legally operated under the noncommercial license held by the licensee.

607.49(4) *Requirements.*

a. The applicant must have two years of previous driving experience. This means that the applicant must have held a license that permits unaccompanied driving for at least two years. This does not include a motorized bicycle license, a minor's school license or a minor's restricted license.

b. The applicant must have a good driving record for the most recent two-year period, as defined in subrule 607.49(5).

c. An applicant who currently holds a commercial driver's license or a commercial driver's instruction permit is not eligible for issuance of a restricted commercial driver's license.

607.49(5) *Good driving record.* A "good driving record" means a driving record showing:

a. No multiple licenses.

b. No driver's license suspensions, revocations, disqualifications, denials, bars, or cancellations of any kind.

c. No convictions in any type of motor vehicle for:

(1) Driving under the influence of alcohol or drugs.

(2) Leaving the scene of an accident.

(3) Committing any felony involving a motor vehicle.

(4) Speeding 15 miles per hour or more over the posted speed limit.

(5) Reckless driving.

(6) Improper or erratic lane changes.

(7) Following too closely.

(8) Accident-connected traffic law violations.

d. No record of at-fault accidents.

607.49(6) *Issuance.*

a. The knowledge and skills tests described in rules 761—607.27(321) and 761—607.28(321) are waived.

b. A restricted commercial driver's license shall be coded with restriction "W" on the face of the driver's license, with the restriction explained in text on the back of the driver's license. In addition, the license shall be issued with a restriction stating the license's validity.

c. The expiration date for a restricted commercial driver's license that is converted to this license from another Iowa license shall carry the same expiration date as the previous license.

d. A restricted commercial driver's license may be renewed for the period of time specified in Iowa Code section 321.196. The licensee's good driving record shall be confirmed at the time of renewal.

e. The fee for a restricted commercial driver's license shall be as specified in Iowa Code section 321.191.

f. There are two periods of validity for commercial motor vehicle operation: March 15 through June 30, and October 4 through December 14. These are referred to as "seasonal periods." Validity shall not exceed 180 days in any 12-month period. Any period of validity authorized previously by another state's license shall be considered a part of the 180-day maximum period of validity.

g. A restricted commercial driver's license must be validated for commercial motor vehicle operation for each seasonal period. This means that the applicant/licensee must appear at a driver's license examination station during the current seasonal period or not more than 30 days before the beginning of the period to have the person's good driving record confirmed. Upon confirmation, the department shall issue a replacement license with a restriction validating the license for that seasonal period, provided the person is otherwise eligible for the license. The fee for a replacement license shall be as specified in Iowa Code section 321.195.

h. The same process must be repeated for each seasonal period.

This rule is intended to implement Iowa Code section 321.176B.

761—607.50(321) Self-certification of type of driving and submission of medical examiner's certificate.

607.50(1) *Applicants for new, transferred, renewed or upgraded CDL.*

a. A person shall provide to the department a self-certification of type of driving if the person is applying for:

(1) An initial commercial driver's license,

(2) A transfer of a commercial driver's license from a prior state of domicile to the state of Iowa,

(3) Renewal of a commercial driver's license, or

(4) A license upgrade for a commercial driver's license or an endorsement authorizing the operation of a commercial motor vehicle not covered by the current commercial driver's license.

b. The self-certification shall be on a form or in a format, which may be electronic, as provided by the department.

607.50(2) *Enrollment of existing CDL holders.* Every person who holds a commercial driver's license on or after January 30, 2012, and up to January 30, 2014, and who has not otherwise made a self-certification of type of driving under subrule 607.50(1) shall make to the department a self-certification of type of driving. The self-certification may be made on or after January 30, 2012, but must be made no later than January 29, 2014.

607.50(3) *Submission of medical examiner's certificate by persons certifying to non-excepted interstate driving.* Every person who self-certifies to non-excepted interstate driving must give the department a copy of the person's current medical examiner's certificate. A person who fails to provide a required medical examiner's certificate shall not be allowed to proceed with an initial issuance, transfer, renewal, or upgrade of a license until the person gives the department a medical examiner's certificate that complies with the requirements of this subrule, or changes the person's self-certification of type of driving to a type other than non-excepted interstate driving. For persons submitting a current medical examiner's certificate, the department shall post a medical certification status of "certified" on the person's CDLIS driver's record. A person who self-certifies to a type of driving other than non-excepted interstate shall have no medical certification status on the CDLIS driver's record.

607.50(4) *Maintaining certified status.* To maintain a medical certification status of "certified," a person who self-certifies to non-excepted interstate driving must give the department a copy of each

subsequently issued medical examiner's certificate valid for the person. The copy must be given to the department at least ten days before the previous medical examiner's certificate expires.

607.50(5) *CDL downgrade.* If the medical examiner's certificate or medical variance for a person self-certifying to non-excepted interstate driving expires or if the Federal Motor Carrier Safety Administration notifies the department that the person's medical variance was removed or rescinded, the department shall post a medical certification status of "not certified" to the person's CDLIS driver's record and shall initiate a downgrade of the person's commercial driver's license. The medical examiner's certificate of a person who fails to maintain a medical certification status of "certified" as required by subrule 607.50(4) shall be deemed to be expired on the date of expiration of the last medical examiner's certificate filed for the person as shown by the person's CDLIS driver's record. The downgrade will be initiated and completed as follows:

a. The department shall give the person written notice that the person's medical certification status is "not certified" and that the commercial driver's license privilege will be removed from the person's driver's license 60 days after the date the medical examiner's certificate or medical variance expired or the medical variance was removed or rescinded unless the person submits to the department a current medical certificate or medical variance or self-certifies to a type of driving other than non-excepted interstate.

b. If the person submits a current medical examiner's certificate or medical variance before the end of the 60-day period, the department shall post a medical certification status of "certified" on the person's CDLIS driver's record and shall terminate the downgrade of the person's commercial driver's license.

c. If the person self-certifies to a type of driving other than non-excepted interstate before the end of the 60-day period, the department shall not remove the commercial driver's license privilege from the person's driver's license, and the person will have no medical certification status on the person's CDLIS driver's record.

d. If the person fails to take the action in either paragraph 607.50(5)*"b"* or *"c"* before the end of the 60-day period, the department shall remove the commercial driver's license privilege from the person's driver's license and shall leave the person's medical certification status as "not certified" on the person's CDLIS driver's record.

607.50(6) *CDL downgrade of existing CDL holders who fail to enroll before January 30, 2014.* Every person subject to subrule 607.50(2) who fails to make a self-certification of type of driving or fails to give the department a copy of the person's medical examiner's certificate as required by subrule 607.50(3) before January 30, 2014, shall be subject to a CDL downgrade. The department shall post a medical certification status of "not certified" to the CDLIS driver's record and shall initiate a downgrade of the driver's commercial driver's license following the procedure set forth in subrule 607.50(5). In such cases, the 60-day period shall begin January 30, 2014, and the person shall be required to make an initial self-certification of type of driving to terminate the CDL downgrade and to avoid removal of the commercial driver's license privilege. The person's status and privilege under subrule 607.50(5) shall be determined according to the certification made or not made.

607.50(7) *Establishment or reestablishment of "certified" status.* A person who has no medical certification status or whose medical certification status has been posted as "not certified" on the person's CDLIS driver's record may establish or reestablish the status as "certified" by submitting a current medical examiner's certificate or medical variance to the department. A person who has failed to self-certify to a type of driving or has self-certified to a type of driving other than non-excepted interstate must also make a self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of "certified" on the person's CDLIS driver's record.

607.50(8) *Reestablishment of the CDL privilege.* A person whose commercial driver's license privilege has been removed from the person's driver's license under the provisions of paragraph 607.50(5)*"d"* may reestablish the commercial driver's license privilege to the person's driver's license by either of the following methods:

a. Submitting a current medical examiner's certificate or medical variance to the department. A person who has failed to self-certify to a type of driving must also make an initial self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of "certified" on the person's CDLIS driver's record and reestablish the commercial driver's license privilege to the person's driver's license, provided that the person otherwise remains eligible for a commercial driver's license.

b. Self-certifying to a type of driving other than non-excepted interstate. The department shall then reestablish the commercial driver's license privilege to the person's driver's license, provided that the person otherwise remains eligible for a commercial driver's license; the person will have no medical certification status on the driver's CDLIS driver's record.

607.50(9) *Change of type of driving.* A person may change the person's self-certification of type of driving at any time. As required by subrule 607.50(3), a person certifying to non-excepted interstate driving must give the department a copy of the person's current medical examiner's certificate prepared by a medical examiner.

607.50(10) *Record keeping.* The department shall comply with the medical record-keeping requirements set forth in 49 CFR Section 383.73.

This rule is intended to implement Iowa Code section 321.182 and 2011 Iowa Code Supplement sections 321.188 and 321.207.

[**ARC 9954B**, IAB 1/11/12, effective 1/30/12; **ARC 0031C**, IAB 3/7/12, effective 4/11/12]

761—607.51(321) Determination of gross vehicle weight rating.

607.51(1) *Vehicle other than towed vehicle.* For a vehicle other than a towed vehicle that has no legible manufacturer's certification label, the applicant may provide documentation of the gross vehicle weight rating, such as a manufacturer's certificate of origin, a title, a vehicle registration document, or the vehicle identification number information for the vehicle. In the absence of the above documentation, the registered weight of the vehicle shall be presumed to be the gross vehicle weight rating.

607.51(2) *Towed vehicle.* For a towed vehicle without a gross vehicle weight rating specified by the manufacturer, the gross vehicle weight rating shall be its gross weight.

This rule is intended to implement Iowa Code section 321.1.

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